How Health Care Reform Strengthens Medicaid's Role in Ending and Preventing Homelessness: Medicaid Eligibility Expansion

In March 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA). This historic piece of legislation presents significant opportunities to improve access to quality, affordable health care for all Americans. This is particularly true for homeless people and people at risk of homelessness, whose options for accessing physical and behavioral health care services, health promotion services, and chronic disease management programs have historically been limited. This is the first in a series of briefs developed by the Technical Assistance Collaborative, Inc. (TAC), intended to assist advocates who work on behalf of people who are homeless, providers, and policy makers understand and capitalize upon opportunities in the ACA to prevent and end homelessness.

Importance of Medicaid

For many people who are homeless, the lack of access to health insurance can mean a constant struggle to obtain and maintain affordable housing. As a result of not having health insurance, people who are homeless often forgo treatment for chronic health conditions, acute injuries, mental illness, and substance use – making it difficult to focus on the goal of finding housing. Without health insurance, medical crises and ongoing related costs can lead a low-income household down the path to homelessness. It is clear that health insurance provides not only a safety net of needed services – available to help a family at risk of homelessness, but also plays a critical role in helping a person who is homeless access those services needed to regain stability – physical and residential.

Linking people who are homeless to Medicaid – the health insurance program for low-income Americans – has become an increasingly important federal priority. Beginning in 1999, Congress and the U.S. Department of Housing and Urban Development (HUD) required homeless planning groups to strengthen linkages between people who are homeless and mainstream resources, including Medicaid. More recently, the U.S. Interagency Council on Homelessness stated that Medicaid – and the expansion of the program – is the "secret weapon in the fight against homelessness."[1] These federal agencies have recognized that health problems and homelessness are often connected. For some people, the lack of affordable health insurance has forced people who are sick to choose between paying for necessary treatment and paying for a place to live. For some, the lack of treatment for health problems has contributed to or extended their episode of homelessness. For all, the lack of stable, safe, housing serves to exacerbate any physical and/or behavioral health problems.

[1] Ho, Jennifer M. (September, 2010). Using Health Reform to Prevent and End Homelessness. United States Interagency Council on Homelessness. Retrieved from: *http://www.usich.gov/HealthReform.html*

In recent years, homeless providers and advocates have also recognized the importance of Medicaid in addressing homelessness. In many communities, Health Care for the Homeless grantees and other outreach providers have utilized Medicaid to support engagement of chronically homeless people living on the streets, in cars, parks, under bridges, etc. Shelter providers have begun implementing systems to proactively link homeless people to Medicaid and other mainstream benefits while in shelter. Innovative transitional and permanent supportive housing providers have partnered with Medicaid agencies to support ongoing services needed to keep people housed. Agencies that received federal homelessness prevention funding have created strategies to link at-risk households to Medicaid and other critical benefits as a comprehensive effort to stabilize housing situations.

Homeless planning groups across the nation – known as Continuums of Care (CoC) – have also begun to explore systematic ways to develop linkages between homeless people and Medicaid. Recent legislation reauthorizing federal homeless funding made available by HUD has highlighted the role of CoCs in monitoring the ability of providers to help homeless people access Medicaid as well as other mainstream benefits such as Children's Health Insurance Program (CHIP), Supplemental Security Income (SSI), and Supplemental Nutrition Assistance Program (SNAP). [2] In recent years, HUD funding awards have been directly linked to how well a CoC can demonstrate and measure these linkages.

Medicaid is not a new program – it has been around for over 40 years. However, with the enactment of the Affordable Health Act (ACA) in 2010, changes to the Medicaid program will increase the value of this resource in meeting the health and behavioral health needs of homeless people and those people at risk of homelessness. The changes described below will:

- Allow more homeless and at-risk people to access health insurance;
- Allow homeless providers to meet the health care of more low-income people;
- Enable some agencies to shift the cost of providing critical support services for homeless people to Medicaid; and
- Help CoCs better address and end homelessness in communities across the nation.

CHANGES TO MEDICAID ELIGIBILITY

One of the most important changes resulting from the health care reform legislation is the expansion of Medicaid to a larger and more diverse group of people. Currently, to be eligible for Medicaid, a person must meet certain categorical criteria and financial criteria.[3] States are now only required to cover people in certain mandatory groups such as pregnant women, the elderly, people with disabilities, and parents and children below certain incomes levels.

[2] Formerly known as Food Stamps.
[3] For people with disabilities, Medicaid eligibility in most states is tied to their eligibility for SSI. Persons with a sole substance use disorder are not eligible for SSI under current Social Security rules.

In most states, single adults under 65 who are not disabled, even those at or below the federal poverty level, are not eligible for Medicaid. As of 2009, more than half of all states did not cover single adults through the Medicaid program.[4] However, as a result of the ACA, Medicaid eligibility will be broadened to include more low-income individuals. Specifically, as of January 2014, states will be required to cover single adults under 65 with incomes up to 133% of the federal poverty level (equal to approximately $14,400 dollars per year or 32% of the area median income in 2010) through their Medicaid program. Expansion will be covered all, or in part, by a higher contribution or "match" from the federal government.[5] States can elect to make this change prior to 2014, but cannot receive the higher match until 2014.

As a result of this expansion, an estimated 16-22 million new individuals across the nation will now be eligible for Medicaid,[6] including many people who are homeless or at-risk of homelessness. As mentioned earlier, access to health and behavioral health services can often be the critical component to helping homeless people stabilize and achieve residential stability.

Changes to Medicaid Enrollment and Access to Services

While the changes to Medicaid under the ACA will make many more people eligible for Medicaid who were previously ineligible, this does not mean that these people will automatically receive health insurance. Although Medicaid is a federal benefit that is guaranteed to all eligible persons, to receive services a person must first take the initiative to apply and enroll in the program. Raising awareness among homeless providers and discussing the benefits for people who are homeless and households at risk of homelessness of having access to health insurance will be critical to ensuring that eligible individuals actually enroll. Promoting understanding about the changes to Medicaid eligibility rules among outreach workers, primary care providers, shelter staff, and others will also be important as they are key allies in ensuring that people who are homeless are made aware of their eligibility and are helped with the enrollment process.

The addition of the new financial only eligibility group (i.e. people with incomes at or below 133% of the FPL) will allow many people who are homeless access to health insurance for the first time. However, for those who actually enroll under the new eligibility category, the benefit these persons receive might not be as comprehensive as the standard Medicaid benefit. This is because the ACA only requires States

[4] Kaiser Commission on Medicaid and the Uninsured. "Where are States Today? Medicaid and State-Funded Coverage Eligibility Levels for Low-Income Adults." December 2009.

[5] The cost of Medicaid is jointly funded through a partnership between state and federal governments, with states with lower per capita incomes receiving proportionately more federal funding. In order to assist states with paying for the eligibility expansion, the ACA includes provisions for the federal government to pay 100% of the medical costs associated with the expansion of Medicaid for the first three years, with the percentage gradually decreasing to 90% by 2020.

[6] Holahan, J., Headen, I. (2010, May). *Medicaid coverage and spending in health reform: National and state by state results for adults at or below 133% FPL* (Kaiser Commission on Medicaid and the Uninsured Report No. 8076). Washington, DC: Hentry J. Kaiser Family Foundation.

to extend a benchmark or benchmark equivalent plan to the expansion population.[7] Depending on how comprehensive the standard Medicaid benefit is the benchmark plan may include fewer services; though fortunately mental health and substance use services must be included in a state's benchmark plan. People who are homeless can also pursue enrollment in Medicaid under one of the existing eligibility categories. One study found that approximately 50 percent of homeless people presumed eligible for Medicaid were not receiving it.[8] One reason might be the complex Supplemental Security Income (SSI) determination process. SSI is a pathway to Medicaid for people who are disabled in most states. Given the many benefits of SSI, including the potential for access to a more robust Medicaid benefit (persons with disabilities cannot be required to enroll in a benchmark plan) assisting people who are homeless with the SSI process will remain an important strategy for accessing Medicaid benefits.

There are several provisions in the ACA that are intended to simplify Medicaid enrollment and minimize administrative barriers that in the past have made the Medicaid eligibility determination process difficult for many people, particularly people who are homeless. The ACA requires states to streamline Medicaid enrollment procedures in a variety of ways. States will be required to use a "user-friendly" application form that will be developed by the U.S. Department of Health and Human Services (HHS). This form will allow people to apply for all available health insurance programs offered by a state [e.g. Medicaid, CHIP, etc.] in person, via phone, online, or via mail. States will have the flexibility to design their own form that can be more comprehensive then the form designed by HHS. For example, a state could potentially design a process that allows people to complete one application for multiple assistance programs, such as SSI and SNAP, in addition to Medicaid. Additionally, ACA provisions require states to use technology to simplify and reduce the need for documentation required to establish eligibility, and adhere to rules making the counting of income easier – further reducing historical barriers to enrollment for people who are homeless.

As part of the ACA reforms to Medicaid, states will also have the option of permitting hospitals to make presumptive Medicaid eligibility determinations. This would allow a hospital to make a 'temporary' Medicaid eligibility determination based on information available at the time and prevent people who are homeless who are in need of treatment or emergency care from having to wait for needed services. This temporary eligibility determination would be in place for a certain period of time and would follow the person. For example, if a person who is homeless visits a hospital emergency room, the hospital could make a presumptive eligibility determination. If the person is then referred for follow-up care to a mental health clinic, s/he would not only be able to get care at the clinic but also the clinic would be able to bill Medicaid for the cost of the services.

[7] For the regulations defining what constitutes a benchmark or benchmark equivalent plan see 75 FR 23068 located at: *http://www.emedco.info/Register/2010/apr/30/2010-9734.pdf*. As discussed in a SMD letter from July 2, 2010, these regulations will need to be updated to reflect the changes made as part of the ACA that adds mental health and prescription drug coverage to what must be included in a benchmark-equivalent plan.

[8] Technical Assistance Collaborative, Policy Research Associates, the Corporation for Supported Housing (2006). *Assessment of Continuum of Care Progress in Assisting Homeless People to Access Mainstream Resources*.

This ability of hospitals and providers to bill Medicaid for expensive emergency services is critical for reducing the amount of hospital funds that are used to address homelessness. Research has documented that people who are homeless are high utilizers of costly emergency services. A recent study[9] found that over a five year period, a cohort of 119 homeless people living on the streets accounted for 18,384 emergency room visits and 871 medical hospitalizations. The average annual health care cost for individuals living on the street was $28,436, compared to $6,056 for individuals in the cohort who obtained housing. By exercising the presumptive eligibility provision included in the ACA, states would enable hospitals to receive Medicaid reimbursement for emergency services that are provided to homeless people.

It will also be important to have mechanisms in place to ensure that once enrolled in Medicaid, people who are homeless are able to maintain access to their services and benefits over time. Under the current Medicaid rules, states must re-determine a person's eligibility for the program at least annually, however some states conduct this review more often. Putting in place systems to assist individuals in the timely completion of eligibility re-determinations will be as important as promoting first-time enrollment. The ACA simplifies some of the re-determination process, but there may continue to be individuals who lose Medicaid coverage because re-determination paperwork was not completed correctly or on time. This is particularly true for people who are homeless because they lack a permanent address and frequently move making it difficult to receive and retain administrative documents. For people who are chronically homeless, symptoms of their mental illness and substance abuse often impede their ability to respond quickly, often jeopardizing their Medicaid coverage. Some strategies for reducing the likelihood of unintentional disenrollment include:

- Co-locating eligibility specialists at shelters and community health centers who can help facilitate the enrollment and redetermination processes;

- Advocating to your state's Medicaid agency to conduct eligibility re-determinations only once per year is an important way to minimize the risk of losing coverage;

- Advocating to your states Medicaid agency to combine applications for other benefits with the Medicaid application;

- Encouraging people who are homeless to identify an eligibility representative who can receive information and notices from Medicaid on their behalf.

- Make sure the Medicaid application in your state includes a data field for housing status. This will allow for targeted outreach to facilitate the re-enrollment process.[10]

[9] Massachusetts Housing and Shelter Alliance (2010). *Home & Healthy for Good: A Statewide Housing First Program Progress Report*.

[10] Reducing Medicaid Enrollment Barriers for Individuals Who are Homeless: National Health Care for the Homeless Council: August 2010: *www.nhchc.org/HealthReform/ReducingMedicaidBarriersAug2010.pdf*

Enrollment in Medicaid is only the first step in helping people who are homeless gain access to needed treatment services. Helping individuals make connections with the healthcare system and ensuring that the available benefits and services meet the needs of the newly eligible population are also critical. Future TAC issue briefs will explore new Medicaid service options and additional ACA provisions intended to facilitate access to primary care and behavioral health treatment.

Next Steps and Opportunities

The expansion of the Medicaid program presents a significant opportunity to help people who are homeless and other low-income adults gain access to important healthcare services and assist them in gaining residential stability. With state officials currently redesigning their Medicaid programs to incorporate the ACA changes, advocates who work on behalf of people who are homeless, CoCs, and other stakeholders can take the following steps now:

- Gather information about Medicaid in your state. For more information about the Medicaid program in your state go to: *www.cms.gov/MedicaidEligibility/downloads/ListStateMedicaidWebsites.pdf*.

- Identify the key state Medicaid officials. These officials are listed online at: *www.kaisernetwork.org/health_cast/uploaded_files/State_Medicaid_Directors_List_from_NASMD.pdf*.

- Request a meeting with state Medicaid officials to educate them regarding the benefits of having access to health insurance among homeless and other low-income persons.

- Learn about the state's plans for conducting outreach to people that will become eligible for Medicaid as a result of the expansion, particularly homeless people. Explore the possibility of a Health Care for the Homeless grantee, or other homeless outreach agency, becoming an agency authorized to conduct Medicaid outreach and enrollment activities.

- Encourage your state to combine the Medicaid application and enrollment process with applications for other benefits such as SSI, CHIP, Temporary Assistance for Needy Families (TANF), SNAP, etc.

- Encourage your state to consider enrolling eligible persons in Medicaid prior to 2014. Some states such as Connecticut have already taken advantage of the opportunity to extend Medicaid benefits to eligible individuals in advance of 2014.

- Discuss the Medicaid re-determination process to identify possible barriers and to ensure that the needs of people who are homeless are considered. Encourage states to conduct eligibility re-determinations only once per year to minimize the risk of losing coverage.

- Encourage your state to exercise the option to allow hospitals to make presumptive Medicaid eligibility determinations so that people in need of treatment do not need to wait.

- Begin public awareness campaigns to make people who are homeless and providers of services to homeless persons aware of the changes in Medicaid eligibility.

- Work to influence the decision around the benefit design for the expansion population to promote access to Medicaid services that will best meet the needs of that population.