Medicaid, SCHIP, and Homelessness

Summary of Recommendations

- **Protect and strengthen the Medicaid entitlement**
- **Simplify application, enrollment, and recertification processes for Medicaid and SSI, and expedite health coverage for eligible homeless persons**
- **Guarantee the affordability of necessary services for all Medicaid beneficiaries**
- **Guarantee access to comprehensive services for homeless enrollees in managed care plans**
- **Reauthorize the State Children's Health Insurance Program (SCHIP) and appropriate funds to cover all uninsured children and their parents with family income at or below 200% FPL**

The vast majority of homeless Americans lack health insurance, primarily because they do not qualify for public insurance and cannot afford private insurance. Only 33% of surveyed homeless people nationwide and 22% of clients receiving services through the Health Care for the Homeless program (153,041 individuals in 2006) are Medicaid or SCHIP beneficiaries,[1] although more are thought to be eligible but not enrolled.

Current Medicaid/SCHIP policies exclude most homeless people. Most people experiencing homelessness do not qualify for Medicaid under current policy, regardless of their degree of impoverishment or medical need. Poor and homeless adults who are not pregnant, disabled, elderly, or the parents of dependent children – approximately 60% of all people known to be homeless – are ineligible for Medicaid in most states. Since July 1, 2006, persons applying for or renewing Medicaid coverage have been required to present a birth certificate or passport as proof of citizenship. Although this provision was intended to keep illegal immigrants from fraudulent enrollment, it threatens Medicaid coverage for eligible U.S. citizens who lack the necessary documentation. People experiencing homelessness are disproportionately affected by this regulation. States are also being given flexibility to impose heavier cost-sharing burdens upon beneficiaries; these measures undermine the Medicaid entitlement for people with low incomes and people without homes.[2]

Uninsurance increases health risks. Lack of health insurance prevents people from obtaining the health care they need to stabilize or resolve health problems that can cause or prolong homelessness. Lacking resources and health insurance, homeless individuals tend to seek care only in emergencies; this results in more complicated health problems that require costly emergent and/or inpatient care. When homeless individuals with poor health fail to get the care they need, the communities in which they live face negative consequences. The high prevalence of chronic and infectious diseases, mental illness, and addiction disorders among homeless people confirms the seriousness of this risk.

Medicaid and SCHIP help to prevent and end homelessness. Research has shown that people with health insurance have better access to health care than do those receiving safety net services alone.[3] Access to the full array of health services, including appropriate treatment of mental illness and substance use disorders, is essential for the prevention and successful

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[1] Health Resources and Services Administration (HRSA). Health Care for the Homeless Program: 2006 National Aggregate UDS Data, http://www.bphc.hrsa.gov/uds/2006data/National/homeless/NationalTable4ho.htm

[2] Judith Solomon. Cost-sharing and Premiums in Medicaid: What Rules Apply? Center for Budget and Policy Priorities, Feb 2007. http://www.cbpp.org/2-28-07health.htm

[3] Holahan J, Spillman B. Health Care Access for Uninsured Adults: A Strong Safety Net is Not the Same as Insurance. The Urban Institute, Jan 2002. http://www.urban.org/url.cfm?ID=310414

management of the serious and complex health problems that afflict homeless people and those at risk of homelessness.[4]

Recommendations

1. **Protect and strengthen the Medicaid entitlement.**

   A) **Oppose capped allotments and other arbitrary cuts in financing.** Capped allotments to states would undermine the individual entitlement to Medicaid, reduce the program's capacity to help vulnerable individuals during economic downturns, and result in greater numbers of uninsured and homeless people. The Deficit Reduction Act of 2005 made substantial changes to Medicaid based on the same erroneous rationale as block grant proposals; the Administration arbitrarily posited billions of dollars in savings, and lawmakers were instructed to make the program fit the numbers. Medicaid funding caps and cuts are overly simplistic attempts at health care reform that will only exacerbate current problems.

   B) **Expand eligibility to include everyone at or below 200% of the Federal poverty level.** As employment-based coverage becomes less common and more costly – particularly for low-wage workers – the health care safety net must expand (until universal coverage is achieved) to include people who are currently experiencing or financially at risk of homelessness. Increased Federal funding must accompany eligibility expansions to hold current beneficiaries harmless.

   C) **Mandate a comprehensive benefits package – including services in medical respite care facilities and permanent supportive housing – for all covered populations.** Administrative waivers and budget reconciliation measures have allowed States to reduce covered services or increase out-of-pocket costs for even the poorest Medicaid beneficiaries. To protect these individuals and the public health, we recommend the requirement of a comprehensive benefits package (as currently specified in the Social Security statute) for all covered populations. Behavioral health services should be a mandatory Medicaid benefit, in parity with medical services. States also should be required to meet the medical needs of homeless persons in medical respite care facilities to the same extent that the home health care needs of people with stable housing are met. Services provided to permanent supportive housing residents also should be eligible for Medicaid reimbursement. These services provide significant cost savings to the Medicaid program and prevent future hospitalizations.[5, 6]

   D) **Restore Medicaid and SSI eligibility to all groups who lost it under Federal welfare reforms.** Two bills enacted in 1996 terminated Medicaid eligibility for individuals whose addiction was a contributing factor to their disability and for immigrants who legally entered the United States after August 1996, including those who became disabled *after* they immigrated. Eligibility for these persons must be restored, as their lack of insurance increases health risks and costs for everyone.

2. **Simplify application, enrollment, and recertification processes for Medicaid and SSI, and expedite health coverage for eligible homeless persons.** Many State Medicaid

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[4] Bonin E, Brehove T, Kline S, Misgen M, Post P, Strehlow AJ, Yungman J. *Adapting Your Practice: General Recommendations for the Care of Homeless Patients*. Health Care for the Homeless Clinicians' Network, Jun 2004. http://www.nhchc.org/Publications/6.1.04GenHomelessRecsFINAL.pdf

[5] Buchanan D, Doblin B, Sai T, Garcia P. The Effects of Respite Care for Homeless Patients: A Cohort Study. *American Journal of Public Health*; 96 (7): 1278-1281, Jul 2006.

[6] Post P. *Defining and Funding the Support in Permanent Supportive Housing: Recommendations from Health Centers Serving Homeless People*. Prepared by the National Health Care for the Homeless Council for the Corporation for Supportive Housing, Feb 2008. http://www.nhchc.org/PSHReport.pdf

programs have created enrollment barriers that disproportionately affect homeless applicants. These barriers include lengthy and complex enrollment procedures, excessive documentation requirements, poorly trained eligibility workers, and lack of accommodation for persons with limited English proficiency and/or educational and functional limitations.[7, 8] Application, enrollment, and recertification processes must be streamlined to prevent excessive waiting periods, inappropriate rejections, and undue administrative expenses. Expedited access to covered benefits for homeless individuals who are highly likely to qualify for Medicaid, SCHIP, or SSI (which automatically triggers Medicaid coverage in most states) would decrease administrative costs, hasten access to preventive/primary care, and reduce the need for more costly acute/emergent care.

3. **Guarantee the affordability of necessary services for all Medicaid beneficiaries.** Cost-sharing (e.g., co-payments and premiums) indiscriminately deters utilization of primary and preventive health services that could preclude the need for more expensive services later. This is especially true for persons with low income and those in poor health (Solomon 2007). Even a small co-payment for office visits has been shown to reduce utilization of primary care and increase the frequency and duration of hospitalizations. Increases in cost-sharing must be avoided, and all cost-sharing for persons at or below 200% FPL eventually should be eliminated.

4. **Guarantee access to comprehensive services for homeless enrollees in managed care plans.** Homeless people enrolled in Medicaid or SCHIP often have difficulty obtaining services provided through managed care plans.[9] States have enrolled homeless Medicaid beneficiaries into managed care plans without the benefit of cost and utilization data, practice guidelines, or access and quality standards necessary for this population.[9,10] We recommend that State Medicaid programs take the following actions to protect unstably housed people who are enrolled in managed care plans:

   A) Adapt eligibility determination processes to accommodate homeless enrollees.

   i) Assess and record housing status at initial enrollment and on a regular basis thereafter, noting health risks associated with housing instability and providing specialized services accordingly.

   ii) Ensure access to appropriate enrollment/recertification information that addresses the distinct needs of people experiencing homelessness and is conveyed in understandable language.

   iii) Ensure the adequacy of plans into which homeless beneficiaries are auto-enrolled. Providers must have a working knowledge of health problems associated with homelessness.

   iv) Expedite voluntary disengagement from managed care plans for people experiencing homelessness that are choosing to switch plans, obtain services from Federally Qualified Health Centers, or use fee-for-service Medicaid.

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

[8] Eiken S, Galantowicz S. *Improving Medicaid Access for People Experiencing Chronic Homelessness: State Examples.* The MEDSTAT Group, Inc. for CMS/ DHHS. Mar 2004. http://www.cms.hhs.gov/PromisingPractices/Downloads/homeless32904.pdf

[9] Wunsch, D. *Can Managed Care Work for Homeless People? Guidance for State Medicaid Programs* http://www.nhchc.org/Publications/guidance.html and *Searching for the Right Fit: Homelessness & Medicaid Managed Care* http://www.nhchc.org/Publications/search.html. National Health Care for the Homeless Council. Sep 1998.

[10] O'Connell, J. *Utilization & Costs of Medical Services by Homeless Persons: A Review of the Literature & Implications for the Future.* National Health Care for the Homeless Council. Apr 1999. http://www.nhchc.org/Publications/utilization.html

B) **Tailor services to meet the distinct needs of people experiencing homelessness.**

i) ***Involve homeless beneficiaries and their advocates*** in the design, implementation, and evaluation of Medicaid managed care programs.

ii) ***Conduct face-to-face health and social assessments*** shortly after enrollment.

iii) ***Establish linkages to integrated health and social services*** through HCH projects and other providers offering comprehensive, coordinated, and culturally appropriate care.

iv) ***Provide coverage of medically necessary addiction and mental health services*** in parity with coverage for treatment of other health conditions.

v) ***Provide an appropriate range of "wrap-around" services*** including outreach, transportation, case management, 24-hour acute and sub-acute recuperative care in a residential facility, and social and housing services.

vi) ***Deliver services at accessible locations*** such as soup kitchens, drop-in centers, and shelters where people experiencing homelessness feel comfortable and are willing to receive care.

vii) ***Cover and facilitate use of out-of-network services*** if appropriate health and social services are not available to homeless beneficiaries within the managed care plan's provider network.

C) **Ensure responsible oversight and financing.**

i) ***Conduct targeted quality assurance and improvement activities*** that focus on beneficiaries experiencing homelessness.

ii) ***Develop fiscally responsible payment methodologies and reimbursement rates*** for services provided to homeless beneficiaries, based on cost and service utilization data specific to people experiencing homelessness.

5. **Reauthorize the State Children's Health Insurance Program (SCHIP) and appropriate funds to cover all uninsured children and their parents with family income at or below 200% FPL.** SCHIP currently provides high quality, comprehensive, affordable health coverage to more than 4 million children who would otherwise be uninsured. These children have access to vital health care services they would not otherwise be able to afford. Among children under the age of 19 served by the Health Care for the Homeless Program in 2006, 1,620 were SCHIP recipients, 50,898 other homeless children were Medicaid recipients, and 59,226 were uninsured.[11] The Medicare, Medicaid, and SCHIP Extension Act of 2007 which was signed by the president on December 29 extended SCHIP through March 31, 2009. Nevertheless, despite the additional federal SCHIP funding for FY 2008 over and above baseline levels, the available Federal funds are not sufficient to cover many additional SCHIP-eligible children or to support significant expansions in eligibility to higher income levels.[12]

We urge Congress to reauthorize SCHIP and to appropriate $60 billion in new Federal funds over the next 5 years for an expanded SCHIP program that would cover eligible children and their parents with family income at or below 200% of the poverty level. Further, we urge Congress to revisit the issues debated as part of the 2007 SCHIP reauthorization attempt but within the context of a broader effort to reform the U.S. health care system.

[11] HRSA, op.cit., 2006. http://www.bphc.hrsa.gov/uds/2006data/National/homeless/NationalTable4ho.htm

[12] Kenney G. The Failure of SCHIP Reauthorization: What Next? Timely Analysis of Immediate Health Policy Issues. Urban Institute, Mar 2008. http://www.urban.org/UploadedPDF/411628_SCHIPfailure.pdf