

Casualties of Complexity: Why Eligible Homeless People Are Not Enrolled in Medicaid

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The National Health Care for the Homeless Council is a membership organization comprised of health care professionals and agencies that serve homeless people in communities across America. The National Council works to improve the delivery of care to homeless people, and to reduce the necessity for dedicated health care for the homeless programs by addressing the root causes of homelessness.

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EXECUTIVE SUMMARY

The complexity and diversity of state Medicaid programs present significant access barriers for impoverished people lacking residential stability, especially for those without the capacity to document their eligibility in prescribed ways. As a result, many eligible homeless people remain uninsured. Lack of health coverage seriously limits their access to needed health care, and threatens both individual and community health. This document identifies obstacles that prevent eligible homeless people from enrolling in Medicaid, describes how experienced homeless service providers address these problems, and recommends ways in which the obstacles can be surmounted or removed.

Informal observations by Health Care for the Homeless providers that more of their homeless clients are ostensibly eligible for Medicaid than actually enroll stimulated the investigation that resulted in this report. The National Health Care for the Homeless Council sought to find out how serious and pervasive the observed gap between eligibility and enrollment might be, why it occurs, and what can be done to assure that eligible homeless people obtain the comprehensive health coverage they need. We were supported in this endeavor by the Health Care for the Homeless Branch, Division of Programs for Special Populations of the Bureau of Primary Health Care.

The report is divided into eight main sections, a bibliography, and four appendices:

The introductory section sketches a working hypothesis to explain why more eligible homeless people do not enroll in Medicaid, and why this is a public problem.

Section II provides a brief overview of federal Medicaid policy and lists Medicaid covered services that states may provide to categorically and medically needy groups for which federal matching funds are available.

Section III describes the eligibility categories under which homeless people are likely to qualify, and clarifies eligibility criteria that are frequently misunderstood by applicants, service providers, and even Medicaid eligibility workers.

Section IV points to the categories of homeless people that are excluded from Medicaid coverage under federal law, either explicitly or by omission.

Section V reviews barriers identified in the recent literature that have prevented eligible individuals from enrolling in Medicaid.

Section VI presents new information about enrollment barriers that apparently eligible homeless persons are experiencing, and indicates the comparative seriousness of these obstacles from the perspective of case managers in 33 federal Health Care for the Homeless projects. This information was obtained from responses to a survey conducted by the National Health Care for the Homeless Council in November–December 2000. Respondents also indicated what they are doing and what they recommend to get more homeless people on Medicaid. Eight HCH projects in seven states (Kentucky, Massachusetts, New Hampshire, New York, Tennessee, Texas and Wisconsin) provided more extensive information that vividly illustrates why homeless persons who should be eligible for Medicaid fail to enroll. More detailed analyses of survey results and collaborative efforts to address enrollment barriers in several states are contained in the appendices.

Section VII lists five conclusions that are warranted by the preceding information:

1. **People experiencing homelessness who are eligible for Medicaid but not enrolled are primarily**
 - children,
 - custodial parents,

- emancipated youth, and
 - persons with severe mental illness and/or other disabling medical conditions, often in combination with behavioral disorders.
(Nine categories into which these people tend to fall are specified on page 32.)
2. **The most serious and pervasive obstacles to Medicaid enrollment for homeless people across all eligibility categories are:**
 - confusion about eligibility criteria,
 - missing personal or third-party contact information on applications,
 - lack of required documentation to confirm eligibility, and
 - failure to complete enrollment following application.
 3. **Inappropriate disenrollment is a serious problem for homeless beneficiaries, who**
 - do not receive redetermination notices,
 - have difficulty providing required documentation to confirm continued eligibility and/or
 - lose benefits in violation of their due process rights.
 4. **The obstacles that eligible homeless persons face in obtaining Medicaid coverage, such as those listed in conclusion 2, are a function of**
 - system inadequacies,
 - conditions inherent to homelessness, and
 - actions by the states and their contractors
(specified on pages 32–33)
 5. **Aggressive outreach and advocacy by various stakeholders can reduce the percentage of uninsured homeless persons** by as much as 10–30% in some HCH projects (specified on page 33).

Section VIII contains recommendations for homeless service providers, government agencies and elected officials, based on the evidence provided by surveyed HCH projects and contained in the recent literature. These recommendations, listed on pages 34–37, specify what various local, state, and federal entities can do to facilitate Medicaid enrollment for eligible homeless people.

1. **Recommendations for Local Agencies:** Homeless service providers are advised to educate their clients about current Medicaid eligibility criteria, covered services, application/enrollment requirements and procedures, and beneficiaries' rights under their State Medicaid plan. They are encouraged to assist homeless clients in obtaining required documentation, and to help them appeal inappropriate denials of coverage. Homeless health care providers are urged to keep detailed records of all client impairments, and to develop working relationships with local Social Security Administration field office staff and physicians authorized to make disability determinations for SSI-related Medicaid and other State disability assistance. HCH projects are urged to document homeless clients' insurance status routinely, and to identify and address Medicaid enrollment barriers. Aggressive follow-up, client advocacy, and periodic evaluation of these efforts are key in maximizing the number of eligible homeless clients who obtain and retain health coverage under Medicaid. (See page 34.)
2. **Recommendations for the States:** Attention is called to the need for better training and performance monitoring of Medicaid eligibility workers to increase their understanding of current policy and procedures, and to improve their responsiveness to homeless applicants and beneficiaries. State Medicaid agencies are advised to simplify the application form, expedite the enrollment process, provide language-appropriate forms and applicant assistance, and outstation eligibility workers in more Federally Qualified Health Centers where homeless people receive services. Less elaborate documentation requirements are recommended for verification and

reverification of eligibility: Personal interview and assets test requirements should be eliminated; beneficiaries should not be required to resubmit unchanged information to verify continued eligibility; and reverification should occur no more than once annually.

Provision of timely information on the disposition of cases (homeless applications approved or denied, cases recertified or terminated) to homeless service providers is recommended to facilitate follow-up. Community-based, interagency collaboration is suggested as an effective vehicle for identifying and addressing Medicaid enrollment barriers. States are urged to implement federal options to cover more uninsured adults in their Medicaid programs, and to protect beneficiaries' due process rights under federal law. Consolidation of Medicaid eligibility determination within one State agency is advocated to improve administrative coordination and simplicity. (See pages 34–35.)

3. **Recommendations for Federal Agencies:** U.S. Department of Health and Human Services agencies and the Social Security Administration are urged to coordinate efforts to simplify and expedite Medicaid eligibility determination and redetermination, and to assure that eligible homeless persons are not inappropriately denied coverage. In addition,
- **The Health Care Financing Administration (HCFA)** is asked to set national standards for automated Medicaid eligibility determination systems, to promote the provision of simplified, language-appropriate forms and application assistance, and to monitor States' adherence to federal Medicaid law and regulations protecting beneficiaries' due process rights.
 - **The Health Resources and Services Administration (HRSA)** is asked to increase HCH project support for case management and Medicaid application assistance, to educate HCH grantees and service recipients about current Medicaid policy, and to provide technical assistance in designing information systems to enable routine tracking of homeless clients' insurance status.
 - **The Substance Abuse and Mental Health Services Administration (SAMHSA)** is urged to educate policy makers about the importance of Medicaid coverage for all homeless persons with alcohol and drug-related disabilities, and to assure that those with severe mental illness (with or without co-occurring substance abuse problems) are not denied coverage.
 - **The Social Security Administration (SSA)** is encouraged to create Homeless Claims Units in each State Disability Determination Service, similar to the one in Massachusetts, employing claims representatives who are sensitive to homeless individuals and knowledgeable about procedures involved in processing their disability claims.

(See pages 36–37.)

This report is primarily intended for homeless service providers and other advocates who are committed to maximizing access to comprehensive health coverage for people experiencing homelessness. It is also intended for public policy makers and government agencies responsible for administration and modification of the Medicaid program who wish to minimize casualties of the complex systems they have wrought. Finally, it was written as a wake-up call for those who are ultimately responsible for American public health policy—concerned citizens who play an active role in the democratic process. Our ultimate hope is that all of these intended readers may pursue simpler, more inclusive ways to assure adequate, affordable health coverage for everyone in these United States.

I. INTRODUCTION

If you are poor, homeless,¹ under age 65 and living in the United States, your only option for health insurance may be Medicaid, a complicated program that is difficult to understand. Ostensibly a safety net, this health care entitlement program more closely resembles an ancient maze. Its convoluted passages are the result of incremental policies developed over 35 years in 50 different states.

Medicaid was designed in 1965 to cover basic health and long-term care for certain categories of poor Americans: families with dependent children and aged, blind, or disabled individuals. States were given options to include other groups of vulnerable people, add benefits to the basic package, and raise financial ceilings in certain eligibility categories.

States have exercised these options variously or not at all, depending on their financial capacity, public need and historical precedent of providing public support for disadvantaged populations. The result is an *ad hoc* program so administratively complex that whole industries have grown up within the public and private sectors just to interpret and explicate current policy.

The great irony is that in many states, the Medicaid program has become so fragmented and elaborate that many of the people for whom it was intended—especially homeless persons—are unable to negotiate the application and enrollment process. One rejoinder is that experienced guides can make the journey easier. But even workers trained to assist Medicaid applicants are often confused by the frequently changing policies and procedures, and often provide inconsistent advice.

The complexity and diversity of state Medicaid programs present significant enrollment barriers for impoverished people lacking residential stability, especially for those who lack the capacity to document their eligibility in prescribed ways. As a result, many eligible homeless people remain uninsured. Health Care for the Homeless² providers try to fill the gap between eligibility and enrollment, but their resources are limited, and the number of uninsured homeless persons continues to grow.

¹ A homeless individual is defined in section 330(h)(4)(A) of the McKinney Act 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.” The Bureau of Primary Health Care has expanded this definition in its description of Health Care for the Homeless program expectations for federal HCH grantees to capture the many faces of homelessness: “A homeless person is an individual without permanent housing who may live on the streets; stay in a shelter, mission, single room occupancy facility, abandoned building or vehicle; or in any other unstable or non-permanent situation. An individual may be considered to be homeless if that person is ‘doubled up,’ a term that refers to a situation where individuals are unable to maintain their housing situation and are forced to stay with a series of friends and/or extended family members. In addition, previously homeless individuals who are to be released from a prison or a hospital may be considered homeless if they do not have a stable housing situation to which they can return. A recognition of the instability of an individual's living arrangement is critical to the definition of homelessness.” (Principles of Practice for Health Care for the Homeless grantees, Bureau of Primary Health Care/HRSA/DHHS, March 1, 1999)

² Health Care for the Homeless (HCH) is a targeted health program, established by Congress through the McKinney Homeless Assistance Act of 1987, to address the unmet health needs of persons experiencing homelessness. The program was re-authorized in 1996 via the Health Centers Consolidation Act, which consolidated community health centers, migrant health centers, health centers for residents in public housing, and HCH projects under a single, five-year authorization, but retained distinct activities for each of the four programs.

The number of homeless people lacking health insurance significantly depends on the extent to which the states in which they live have expanded eligibility criteria,³ particularly for single adults, who comprise the vast majority of homeless service recipients. Even if all identified enrollment barriers were eliminated, a majority of clients seen by Health Care for the Homeless projects would probably remain uninsured because they do not qualify for coverage under current Medicaid policy.

Here is what we know about homeless people from the 1996 National Survey of Homeless Assistance Providers and Clients (NSHAPC), based on a statistical sample representing the entire United States (Burt, 1999):

Homeless service recipients in the US, 1996	percent
Single adults	66%
Parents accompanied by children	11%
Minor children (< 18 yrs)	23%
Males	68%
Females	32%
Mental health and/or substance abuse problem*	66%
Substance abuse (alcohol or drug) problem	27%
Mental health problem	39%
Uninsured	55%
Medicaid	30%
SSI	11%

* self-reported indicators of mental health and/or substance abuse (alcohol/drug) problems, occurring within the last month

Lack of health insurance is *a serious problem for individuals* experiencing homelessness, whose access to needed health care is often contingent upon their access to comprehensive health coverage. Families running from domestic violence, runaway and “throw-away” youth, immigrant children born in the United States, and persons with developmental delays, mental illness and/or other disabling medical conditions—these are among the homeless people in many communities who should qualify for Medicaid but often do not.

Lack of health coverage for homeless people is also *a public health problem*. When individuals with multiple and complex health conditions fail to get the care they need, there are often negative consequences for the communities in which they live. The high prevalence of infectious diseases (TB, hepatitis, HIV/AIDS and other sexually transmitted diseases), mental illness, and frequently co-occurring addiction disorders in the homeless population attests to the seriousness of this risk.

While getting eligible persons enrolled in Medicaid is a very important part of assuring their access to health care, it is only the first step. There are significant issues surrounding access to care for homeless beneficiaries that will not be addressed in this paper. (*For detailed analyses of these issues and recommendations for dealing with them, see Wunsch, 1998 and the National Health Care for the Homeless Council’s November 1998 comments on proposed rules of the 1997 Balanced Budget Act.*)

On September 7–8, 2000, the Department of Health and Human Services (DHHS) hosted a national conference to discuss strategies to improve access to health care, including mental health and substance abuse services, for families and individuals who are homeless. (*For a summary of issues discussed at that conference, see: www.hcfa.gov/medicaid/homeless/900conf.htm.)* This study likewise

³ Expanded eligibility can be accomplished through optional coverage of categorically needy groups with less restrictive financial criteria, or demonstration programs, or state-only funded programs.

seeks to identify and overcome access barriers to comprehensive health services for low-income and impoverished people whose health risks are exacerbated by homelessness.

The following report specifies obstacles that prevent eligible homeless persons from enrolling in Medicaid, describes how experienced homeless service providers are attempting to address these problems, and recommends ways in which the obstacles can be surmounted or removed. Conclusions and recommendations are based on input from homeless service providers and their clients, and from policy analysts whose published analyses of the Medicaid program are part of the public record.

II. WHAT IS MEDICAID?

Medicaid is a means-tested, federal-state, individual entitlement program in which states can choose to participate or not. The primary incentive for states to participate in the Medicaid program is the availability of federal matching funds to cover 50–90% of the cost of care for specified mandatory and optional groups of eligible persons. The federal match rate depends on the per capita income of the state in comparison to the national per capita income; the lower the state's per capita income, the higher the federal match rate. Most State Medicaid programs do not cover benefits or groups for which federal matching funds are not available, although they have the option to do so. (Schneider and Fennel, 1998; Title XIX of the Social Security Act)

To obtain federal matching funds, states must offer coverage for basic benefits (e.g., medically necessary physician and hospital services) to certain categories of people (low-income pregnant women and infants, children, custodial parents with dependent children, disabled persons and the elderly). Beyond these mandatory categorical requirements, states have considerable discretion in choosing which groups to cover and which financial criteria to use for Medicaid eligibility. Optional “categorically needy” groups that can be covered with federal support share characteristics of the mandatory groups, but have other eligibility criteria that are less restrictive. *(For examples of mandatory and optional categorical groups that can be covered by State Medicaid plans with federal support, see www.hcfa.gov/medicaid/meligib.htm.)*

Currently, all 50 states and the District of Columbia participate in the Medicaid program, covering different benefits for different groups of people, at dramatically different levels of coverage. *(For detailed analyses of federal and state Medicaid eligibility criteria, see Schneider and Fennel, 1998; Westmoreland, 1999; and Bruen, et al, 1999. For the most current information about federal Medicaid policy, see HCFA's State Medicaid Manual at www.hcfa.gov/pubforms/45_smm/sm_03_3_toc.htm.)*

States may obtain waivers of some federal requirements under various provisions of the Social Security Act. Waivers give states some flexibility to design their own programs. Thus it is necessary for those providing entitlement assistance to potential beneficiaries to be well informed about the particular rules affecting Medicaid eligibility in their state. *[For more information about waiver options and which states have implemented them, see: www.hcfa.gov/medicaid/hpg1.htm.]*

Covered Services

To receive federal matching funds, states must offer the following basic services to qualified persons within the “**categorically needy**” population (e.g., low-income families with children, SSI recipients, Medicaid-eligible pregnant women and infants, children meeting particular age and income requirements, and certain Medicare beneficiaries):

- inpatient and outpatient hospital services;
- physician services;
- medical and surgical dental services;
- nursing facility services for adults aged 21 or older;
- home health care for persons eligible for nursing facility services;
- family planning services and supplies;
- ambulatory services offered by rural health clinics that are covered under the State plan;
- laboratory and X-ray services;
- pediatric and family nurse practitioner services;
- ambulatory services offered by federally qualified health centers that are covered under the State plan;
- nurse-midwife services; and

- early and periodic screening, diagnosis, and treatment (EPSDT) services for persons under age 21.

States choosing to cover a “*medically needy*” population (i.e., with income exceeding “categorically needy” limits who may “spend down” to Medicaid eligibility under the State’s Medicaid plan by incurring medical and/or remedial care expenses) must provide the following services to these individuals:

- prenatal care and delivery for pregnant women;
- ambulatory services for children under age 18 and for individuals entitled to institutional services;
- home health services for individuals entitled to nursing facility services; and
- institutional or intermediate services for persons with mental illness or mental retardation that are covered under the State plan.

Federal matching funds are also available to States choosing to cover *other optional services*, which commonly include:

- clinic services;
- nursing facility services for individuals under age 21;
- intermediate care facility/mentally retarded services;
- optometrist services and eyeglasses;
- prescribed drugs;
- TB-related services for persons with TB infection;
- prosthetic devices;
- dental services;
- home and community-based care waiver services including case management, personal care, respite care,⁴ adult day health, homemaker/home health aide, habilitation, and other State requested, HCFA-approved services; and
- medical services for women with breast or cervical cancer or precancerous conditions.

(HCFA: www.hcfa.gov/medicaid/mservice.htm)

Mental health and substance abuse services are covered under a number of these categories.⁵

States can impose limitations in amount, duration and scope of covered services. They may also place appropriate limits on a service based on such criteria as medical necessity or utilization control procedures. However, each service must be “sufficient in amount, duration and scope to reasonably achieve its purpose.” (42 CFR 440.230)

⁴ Respite care here refers to temporary or periodic services provided to a functionally impaired individual for the purpose of relieving the regular caregiver.

⁵ Hospital inpatient and outpatient mental health and substance abuse treatment is a mandatory service, except for services provided in Institutions for Mental Diseases to persons aged 21–65, which are not covered by Medicaid. Mental or behavioral health services provided in a clinic or rehabilitation facility are optional services that can also be covered under a home and community-based care waiver.

III. WHO IS ELIGIBLE?

In general, to qualify for Medicaid, an individual must meet both *financial* (income/resource) requirements and *non-financial* (categorical, immigration status and residency) requirements, as stipulated under federal Medicaid policy and by the Medicaid program in the state where he or she resides. (Schneider and Fennel, 1998) Financial requirements are complicated by variations in income standards and the methodologies used to calculate them across different eligibility categories, and by whether both income and assets tests are required.⁶ Non-financial requirements have been complicated by significant policy changes during the last decade, which expanded eligibility options for some groups while restricting them for others.

Medicaid benefits are not guaranteed indefinitely for those who qualify. Eligibility is redetermined (“recertified” or “reverified”) periodically, ranging from every 30 days to once every 12 months, depending on state policy. The federal requirement is that states redetermine eligibility for recipients only once every 12 months, or if circumstances affecting eligibility change. Only employees of the single State Medicaid agency or welfare agency (if different and so authorized) are authorized to determine Medicaid eligibility.

Because homeless people frequently move from state to state and have fluctuating monthly income, their eligibility for Medicaid coverage and for particular covered benefits may also fluctuate, depending on where they are at a given time and whether they are working or not. Nevertheless, those who do qualify even intermittently tend to fall within one or more of the following categories:

- **Pregnant women and infants** All states participating in the Medicaid program are required to provide health coverage for pregnant women and infants with family incomes at or below 133% of the federal poverty level (FPL)—i.e., \$19,458 per year for a family of three in 2001. Coverage is guaranteed up to 60 days *post partum* for the mother and through the first year of life for the child. States have the option to raise the income eligibility level to 185% FPL or higher. As of October 2000, 33 states and the District of Columbia had met or exceeded this level, and 12 states and the District of Columbia covered pregnant women at or above 200% FPL. (NGA, 2001) Resource or assets standards are not mandatory for these groups, but if states choose to require them, they must be no more restrictive than those used for pregnant women under the Supplemental Security Income (SSI) program, or those used for infants under the old Aid to Families with Dependent Children (AFDC) program. Pregnant adolescents may also qualify for Medicaid at state option, discussed below.
- **Low-income children** There are several options for children’s health coverage in most states under the Medicaid program and/or the *State Children’s Health Insurance Program (SCHIP)*, through which children from working families with incomes too high to qualify for Medicaid but too low to afford private insurance can obtain health coverage. All 50 States and the District of Columbia have implemented a SCHIP program by expanding Medicaid, or creating a separate state program, or both. (NGA, 2001) Federal income thresholds for children under categorical Medicaid vary by age. The minimum family income level is 133% of the federal poverty level (FPL) for children under age 6, and 100% FPL for children 6–14. States with expanded Medicaid/SCHIP programs have increased income thresholds to 200–300% FPL for children under age 18 or 19.

⁶ Income is anything received that can be used to meet day-to-day needs or for food, clothing, or shelter. Examples of assets are savings accounts, real estate investments, insurance policies, and personal belongings worth less than a certain amount, depending on the eligibility category. (Westmoreland, 1999; Social Security Act)

Almost all homeless children are eligible for one of these programs, and most are income-eligible for categorical Medicaid. In 1999, 85% of Health Care for the Homeless clients had income below 100% FPL, 5% between 100–200% FPL, and only 1% exceeded 200% FPL. (BPHC, 1999) The mean homeless family income reported in the 1996 Homeless Assistance Survey was only 46% of the federal poverty level at that time (\$475 per month). Homeless children in families under age 18 represented at least 23% of homeless assistance program users in 1996, and 73% of those surveyed were on Medicaid. (Burt 1999) In 1998, the U.S. Conference of Mayors' survey of homelessness in 30 cities found that children under the age of 18 accounted for 25% of the urban homeless population.

Presumptive eligibility Federal matching funds are currently available to states opting to grant short-term coverage of medically necessary health services to two categorically needy groups: pregnant women and children who appear to meet income standards for Medicaid or the State Children's Health Insurance Program (SCHIP). Persons deemed "presumptively eligible" for Medicaid/SCHIP by a "qualified entity" may receive immediate, temporary health services while their eligibility is being determined. The State may authorize the following "qualified entities" to grant presumptive eligibility: county health departments, hospital clinics, Federally Qualified Health Centers, pediatricians, WIC programs, Head Start centers, and agencies that determine eligibility for subsidized childcare. (NGA, 2001; Cohen Ross, 1997)

Presumptive eligibility was originally designed to enable low-income women with medically verified pregnancies to obtain early access to prenatal care (within the first trimester of pregnancy). Women deemed presumptively eligible for Medicaid are entitled to coverage of all pregnancy related services for 45 days, pending the state's determination of eligibility. As of October 2000, 29 states and the District of Columbia had implemented this option for pregnant women. (NGA, 2001) Since 1997, expedited Medicaid/SCHIP enrollment has also been available to facilitate early access to primary and preventive care for low-income children. Seven states (Connecticut, Massachusetts, Nebraska, New Hampshire, New Jersey, New Mexico and the District of Columbia) have authorized presumptive Medicaid eligibility for children, and six states (Massachusetts, Michigan, Nebraska, New Jersey, New Mexico and New York) offer presumptive eligibility to children under their SCHIP programs. (Cohen Ross, 1997; NGA, 2001)

Continuous eligibility States may also grant continuous eligibility for Medicaid/SCHIP to pregnant women (up to 10 months of coverage) and children (up to 12 months of coverage), regardless of changes in employment or family income during that period, to prevent interruption of care that often results when income must be verified monthly or quarterly. Eighteen states allow continuous Medicaid eligibility for pregnant women, and 33 states offer continuous eligibility for children qualifying for Medicaid or SCHIP. (See NGA, 2001 for a list of states providing continuous eligibility for pregnant women and children as of October 2000.)

- **Persons with mental and/or physical disabilities** may be eligible for disability-based Medicaid associated with the federal Social Security Income (SSI) program or other state disability assistance. Eligibility and application requirements vary among the states. In 32 states and the District of Columbia, SSI eligibility results in automatic Medicaid coverage. In seven other states (Alaska, Nevada, Oregon, Idaho, Utah, Nebraska, and Kansas), a separate application for Medicaid is required, but the same disability criteria are used as in the federal SSI program. In these states, the State Medicaid agency makes the eligibility determination rather than the local SSA field office. In 11 states (Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma and Virginia), at least one standard for disability-based Medicaid eligibility is more restrictive than the federal SSI standard. That is, there is a narrower definition of disability or a lower income or assets threshold, and/or more restrictive methods are used to count income or assets. (Bruen, et al, 1999) These states are

authorized to use standards that were already in place before SSI was implemented in 1972. In Massachusetts, disabled persons can qualify for federal disability and/or Medicaid without applying for SSI, under the state demonstration program. (See Bruen, et al, 1999, for a comparative analysis of states' Medicaid eligibility standards for aged, blind and disabled people.)

To qualify for **SSI-related Medicaid**, an individual must be determined disabled according to the federal definition, and have income and countable assets that are below federally defined levels. A *disabled individual* is defined as

an adult who is unable to engage in substantial gainful activity or a child who has marked and severe functional limitations, by reason of a medically determined physical or mental impairment expected to result in death, or that has lasted or can be expected to last continuously for 12 months. (Westmoreland, 1999; Social Security Act)

If disability claimants do not have enough medical evidence of a physical or mental impairment from their treating physician to determine whether they meet this federal definition of disability, the local Social Security office (“district office”) will purchase a “consultative examination.” This is part of the medical review of the claim, which is done by the Disability Determination Service that contracts with the Social Security Administration in each state. Under the regulations, the SSA may send claimants to their personal physicians or to HCH projects or federally funded Community Health Centers for consultative examinations. In certain cases, the SSA may find a claimant eligible for “presumptive” SSI benefits that can be paid for up to six months while evidence is being gathered for a full disability determination. (Rosen, 2001)

(To learn how HCH clinicians can provide appropriate documentation of impairments in support of their patients' applications for SSI, see O'Connell, 1997 for an efficient and effective approach to documenting physical impairments, and McKee, 2000 for guidance in documenting mental impairments. See Rosen, 2001 for other ways in which homeless service providers can facilitate disability claims for homeless clients.)

In 1996, Congress rescinded SSI eligibility for persons with a disability caused by an addiction disorder. Because SSI disability assistance is linked to Medicaid eligibility in most states, this means that *persons whose drug abuse and/or alcoholism (DA&A) is “material” in the determination of their disability —i.e., who would not be deemed disabled if they stopped using drugs or alcohol—can no longer qualify for SSI-related Medicaid.* (National Health Care for the Homeless Council and the National Law Center on Homelessness & Poverty, 1998) Although the Social Security Administration expected that 70% of SSI recipients whose coverage was terminated for alcohol or drug-related reasons would still qualify for Medicaid under SSI or another eligibility category, only about 35% have done so. (Schlosberg, 1997; Lewin Group, 1998, as cited in Swartz et al, 2000)

HIV/AIDS, tuberculosis and severe mental illness are among many chronic, disabling conditions that are more prevalent among homeless people than in the general population. The prevalence of HIV infection is at least three times higher in homeless populations studied than in the general population. (Song, 1999) Homeless people are at high risk for tuberculosis because they sleep and congregate in crowded settings where people commonly infected with the disease (particularly immigrants and persons with HIV infection) congregate. Poor health and nutrition exacerbated by drug addiction, alcoholism, and limited access to health care further increase the risk of TB infection, resulting in average prevalence rates of 32–43% among homeless adults. (National Health Care for the Homeless Council, 1994; McMurray-Avila et al, 1998; NIAID, 1999)

Research indicates that about one-third of homeless people residing in shelters have significant mental illness. Persons with significant functional impairment from severe and persistent mental illness are estimated to represent as much as 20–25% of the homeless population. (McMurray-Avila, 1998)

All of these conditions may qualify homeless persons for disability-based Medicaid, if symptoms impairing functional capacity persist or are likely to persist for 12 months or longer, and if impairments are appropriately documented by an authorized physician. (See O'Connell, 1997 and McKee, 2000.) Of homeless service users included in the 1996 NSHAPC study, 3% reported having HIV/AIDS, 3% reported having TB, 39% reported indicators of mental health problems, and 11% qualified for SSI. (Burt, 1999)

- **Families with dependent children** Persons who currently meet July 1996 standards for the old Aid to Families with Dependent Children (AFDC) program—replaced by Temporary Assistance to Needy Families (TANF) program in August 1996—are eligible for Medicaid. That is, “*they must live in families with dependent children under age 18 in which one parent is absent from home continuously, incapacitated, unemployed or deceased.*” In addition, family income and other resources may not exceed certain levels, which vary from state to state. In 1999, the average income eligibility standard for a family of three was \$5,413 per year (39.1% FPL), and countable assets could not exceed \$1,000 per family unit, excluding exemptions specified by state law. (Westmoreland, 1999)

Section 1931 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) gave states the option to raise the financial ceiling for Medicaid eligibility and to extend eligibility to parents of Medicaid eligible children. (See www.hcfa.gov/medicaid/welfare.htm.) Three states (Alaska, Florida and Illinois) have raised their need standards (Peller and Shaner, 1998), and six states (Wisconsin, Mississippi, Illinois, Missouri, Oklahoma and Pennsylvania) have eliminated assets tests for families with children (Sherman, 2000). Six states (Wisconsin, Connecticut, New York, California, Missouri and Rhode Island) and the District of Columbia have extended eligibility to parents of children on Medicaid in families with incomes ranging from 150–200% FPL. (Sweeney, et al, 2000) Nevertheless, in most states, financial requirements for non-pregnant adults remain more stringent than for pregnant women, custodial adults with dependent children, and children.

To remain eligible for Medicaid, non-pregnant adults may also have to meet work requirements of the TANF program. To date, 36 states have elected to terminate Medicaid for TANF recipients who refuse to work. (See www.acf.dhhs.gov/programs/ofa/WRKREL.HTM.) *Pregnant women and children within certain poverty levels may NOT have their Medicaid terminated for failure to meet TANF work requirements. Nor do other household members lose Medicaid eligibility when one person loses TANF for failure to work or for any other reason.* (Westmoreland, 1999) Moreover, *states are no longer permitted to impose a Medicaid sanction on custodial parents for failure to cooperate with child support enforcement, unless that failure is simultaneously a failure to cooperate in obtaining medical support.* (See Schlosberg, 1998: www.healthlaw.org/pubs/med1998accessmedicaid.html)

When persons lose TANF eligibility, they may still be eligible for Medicaid for at least a year after cash assistance has ended. If family earnings increase above the income threshold required for Medicaid eligibility under the state welfare plan, **transitional Medicaid** is guaranteed for up to 12

months if the following conditions are met:

- 1) *The individual must have been eligible for Section 1931 Medicaid for at least three of the past six months;*
 - 2) *Medicaid eligibility must have been lost due to an increase in income due to hours or earnings; and*
 - 3) *Earnings must be reported quarterly to verify this increase.*
 - 4) *For the family to be eligible, there must be a child in the home.*
 - 5) *The family's income cannot exceed 185% FPL for the second six months.*
- (Peller and Shaner, 1998; PRWORA)

State Medicaid waivers can make a significant difference in continuity of coverage under the TANF-Medicaid program. For example, in Massachusetts, persons who qualify for TANF automatically get 12 months of Medicaid coverage without having to verify their income quarterly.

The NSHAPC study found that members of homeless families comprised 34% of homeless service users in 1996—23% of these family members were children under age 18, and 11% were their parents. (Burt, 1999) Currently, 45 federal HCH grantees (33%) serve homeless families with children. Families with dependent children represent one of the fastest growing segments of the homeless population nationwide, accounting for 38% of those who become homeless each year in our nation's cities. In some cities, the percentage is even higher. (Institute for Children and Poverty, 1999) In rural areas, families, single mothers, and children make up the largest group of people who are homeless (Vissing, 1996). Of 2,000 homeless families surveyed in 20 cities, approximately 57% received TANF, and 53% were on Medicaid in 1999. Ten percent of these homeless families had their Medicaid reduced or terminated within the last year. (Institute for Children and Poverty, 1999)

- **Persons qualifying for other federal assistance programs** Medicaid provides partial coverage for Medicare beneficiaries with income and assets below specified levels. (See *Westmoreland, 1999 for a detailed analysis of these different eligibility categories.*) State Medicaid programs also have the option of paying COBRA continuation payments for eligible individuals with income and assets below specified levels. Only 2% of HCH clients were on Medicare in 1999, and it is unknown how many of these individuals were dually eligible for Medicaid. (BPHC, 1999) The number of homeless persons qualifying for Medicaid under COBRA, if any, is also unknown.
- **Medically needy persons** States may provide optional Medicaid coverage for individuals meeting categorical requirements (i.e., children, pregnant women, adults with dependent children, and aged, blind or disabled individuals) who don't meet financial standards for federal cash assistance programs (such as SSI or TANF) but do meet slightly higher financial standards that are within special "medically needy" limits defined by each state. (Westmoreland, 1999) A majority of states have elected this Medicaid eligibility option,⁷ also known as **Medicaid spend-down**, which allows individuals who would otherwise be over-income for Medicaid to qualify for

⁷ States that do NOT cover the medically needy population under Medicaid are: Alabama, Arkansas, Arizona, Colorado, Delaware, Indiana, Mississippi, Missouri, Nevada, New Mexico, Ohio, South Carolina, South Dakota and Wyoming. (Bazelton, 2001)

the program, and allows states to receive federal matching funds to help finance a portion of their medical care.

In states that elect this option, persons can qualify for Medicaid when their countable income minus approved medical expenses is less than the medically needy income level specified by the state Medicaid program. In other words, the applicant must incur a certain amount of approved medical expenses before Medicaid will cover other medical bills. After the applicant meets the medically needy limit, Medicaid will pay for all covered services for the rest of the “spend down” period (one to six months, at state option, according to HCFA.) For example, in New York, individuals whose income minus medical expenses is within 87% FPL and whose resources are under \$3,500 may qualify for spend-down Medicaid under the medically needy program. (Bruen, et al, 1999)

- **Immigrants** Coverage for emergency care (except for care and services related to an organ transplant procedure) is available to anyone in the United States who meets categorical Medicaid requirements, regardless of immigration or insurance status. To be eligible for **emergency Medicaid**, non-citizens must meet all Medicaid eligibility standards established by the state *except* declaration and verification of immigration status. “*This means that hospitals and other providers are not required to and indeed should not attempt to verify an alien’s immigration status as a condition of receipt of emergency services or for any other reason,*” according to the National Health Law Program. Emergency Medicaid coverage is limited to treatment of an *emergency medical condition*, defined as:

a medical condition (including an emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in (a) placing the patient’s health in serious jeopardy, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.

Treatment does not have to occur immediately after the onset of illness or injury to be covered under emergency Medicaid. (Schlosberg, 1998)

Undocumented (“illegal”) immigrants are eligible only for emergency Medicaid and for public health assistance (immunizations, testing and treatment for symptoms of communicable disease).

Naturalized citizens and **all children born in the U.S.** (including those born to undocumented immigrants) who meet financial and non-financial eligibility requirements are entitled to both emergency and non-emergency Medicaid benefits.

Qualifying for non-emergency Medicaid benefits is more difficult for immigrants who are **legal residents** but not citizens, especially since passage of PRWORA in 1996. In addition to meeting financial and non-financial eligibility requirements,

1. *Legal immigrants must be permanent resident aliens with 40 qualifying quarters of work to qualify for full Medicaid coverage.*
2. *If they were lawfully residing in the U.S. before enactment of PRWORA on August 22, 1996, their coverage is limited to seven years from the date of immigration. Unless they qualified for SSI-Medicaid, states have the discretion to determine whether to continue their eligibility after the seven-year period.*

3. *If they entered the U.S. after August 22, 1996, they may be barred from Medicaid coverage for five years after their immigration date, unless they qualify for SSI-Medicaid. Thereafter, states may determine whether they qualify for full Medicaid coverage.*
4. *Persons granted asylum, refugees, individuals granted withholding of deportation, Cuban and Haitian entrants, and Amerasian immigrants are also subject to the seven-year rule unless they qualify for SSI-Medicaid.*
5. *Income and resources of all legal immigrants entering the U.S. after enactment of PRWORA must be deemed to include the income and resources of their sponsors and their sponsors' spouses. Sponsors (adult citizens or nationals who petition for the admission of an immigrant family member) must sign affidavits of support obligating them to reimburse state and federal governments for non-emergency Medicaid expenditures made on behalf of the legal immigrants they are sponsoring. These "deeming" provisions make it extremely difficult for immigrants to meet income eligibility requirements for Medicaid. (Westmoreland, 1999)*

(See National Alliance to End Homelessness, 1998 for a detailed analysis of laws related to immigration and their impact on homeless assistance providers.)

- **Other eligibility categories in states with Medicaid demonstration programs** Some states have chosen to offer Medicaid coverage to people within other optional eligibility categories, particularly those with demonstration programs authorized under Section 1115 of the Medicaid statute. Among the groups of people who can qualify under these expanded Medicaid programs are:

Single adults meeting particular employment and/or income standards

Under MassHealth, the 1115 Medicaid demonstration project in Massachusetts, persons who have not worked during the past 12 months or employed persons with income under \$3,000 can qualify for Medicaid. (For more information, see: www.state.ma.us/dma/masshealthinfo/regulations_eligibility/regs_eligibility_toc.htm.)

In New York, single adults and noncustodial parents with income at 100% FPL or lower have been categorically eligible for Medicaid (Safety Net Assistance) under the state's 1115 waiver since 1997. In 2000, New York State expanded the financial ceiling for this group, pending HCFA approval, to 150% FPL under a Medicaid managed care-only option called Family Health Plus. (For more information, see: www.citizenactionny.org/famhlthplus.html.)

Uninsurables In Tennessee, medically vulnerable individuals ("uninsurables") who have been denied private health coverage because of a pre-existing medical condition are eligible for TennCare, the state's 1115 Medicaid demonstration project. Nonpregnant adults with income above 100% FPL are obligated to pay premiums and copayments for all but preventive care on a sliding scale. Rates for recipients above 200% FPL are comparable to those charged by the private insurance industry. Benefits are the same as those to which categorical Medicaid eligibles are entitled. *(For current rates, see www.state.tn.us/tenncare/pdf/prempov.pdf.)* Many working homeless people who qualify under this eligibility category are disenrolled for failure to pay premiums, often because they do not receive premium notices, or because they fail to report changes in income after becoming homeless.

IV. WHO IS NOT ELIGIBLE?

A substantial number of homeless people are unlikely to qualify for Medicaid in any state. Among these are:

- **Non-disabled, non-pregnant adults under age 65 unaccompanied by dependent children** According to the NSHAPC study, 66% of homeless assistance program users nationwide in 1996 were single adults not in families (without accompanying children). Only 30% of homeless adults surveyed were on Medicaid, and 55% had no health insurance of any kind. (Burt, 1999) Because single, non-disabled adults are not eligible for Medicaid in most states, even if enrollment barriers could be eliminated for currently eligible homeless people, these categorical limitations would still exclude large numbers of homeless persons from Medicaid coverage.

Medicaid eligibility categories... have the effect of excluding millions of poor men and women from Medicaid, regardless of their degree of impoverishment or medical need. Women who are not pregnant, not disabled, not elderly, or do not have dependent children are ineligible for Medicaid. The same applies to men living in poverty. Compared to low-income children, low-income adult men and women are two to three times more likely to be uninsured.
(Schneider and Fennel, 1998)

- **Persons with disabilities that are primarily attributable to substance abuse** As noted on page 11, SSI-related Medicaid is no longer available to persons with disabilities that are secondary to alcohol or drug use. A number of such persons lost Medicaid coverage after this new policy became effective in 1996. Many were terminated inappropriately, before reassessment of co-occurring disabilities (such as severe mental illness) or an *ex parte* determination of eligibility under any other category in the state Medicaid plan had been conducted. (Schlosberg, 1997) There is also evidence that persons most in need of disability benefits, including those with severe psychiatric impairments, are also those least able to complete the reapplication (or initial application) process. (Lewin Group, 1998; Swartz JA, et al, 2000)

Substance abuse contributes to a wide range of health problems resulting from self-neglect and poor hygiene, nutritional deficiencies, trauma, exposure, accidents, victimization, toxic effects of ingested substances, and communicable disease. (McMurray-Avila, et al, 1998) Exclusion of homeless persons with DA&A-related disabilities from Medicaid has a serious impact on their health and their access to health care.

Of all homeless service users surveyed in 1996, 20% had self-reported alcohol or drug problems unassociated with another mental health problem; an additional 23% reported co-occurring alcohol and/or drug problems with other mental illness. Two-thirds of surveyed homeless persons (66%) reported indicators of one or more of these problems occurring within the last month. (Burt, 1999) The research literature indicates that “about half of homeless people studied have had a diagnosable substance abuse disorder at some point in their lives, with a history of alcohol abuse occurring in almost half of single adults who are homeless, and a history of drug abuse in approximately one-third.” Prevalence rates are even higher in some areas and for particular sub-populations. (McMurray-Avila, et al, 1998)

- **Persons with asymptomatic HIV infection** are not eligible for SSI-Medicaid under current federal policy, despite the fact that they meet diagnostic criteria for AIDS used by the Centers for Disease Control and Prevention. This means that such persons cannot begin antiretroviral treatment to suppress their disease until it is at a more advanced stage. (*For a description of AIDS*

symptoms that are required for Medicaid eligibility, see Westmoreland, 1999.) Only 15.6% of homeless individuals with HIV/AIDS have any kind of medical insurance. (Arno, 1996, as cited in Song, 1999) Two states (Massachusetts and Maine) and the District of Columbia have HCFA-approved 1115 Demonstration Projects to provide Medicaid coverage for persons with asymptomatic HIV infection, but the policy is operational thus far only in Massachusetts. (HCFA, 2001)

- **Undocumented immigrants**, as noted on page 14, are eligible only for emergency Medicaid and public health services. In many parts of the country, there are large numbers of homeless, undocumented immigrants living in extreme poverty who are unable to afford non-emergent health care. Many of them are in poor health secondary to infectious diseases contracted in their home country, and other chronic health conditions (such as diabetes and hypertension) that are exacerbated by lack of access to health coverage and health care.
- **Incarcerated persons** Most states have procedures that terminate Medicaid eligibility automatically while someone is in jail, and it can take several weeks for inmates to regain benefits after release, particularly for those with disability-based Medicaid whose SSI benefits have been suspended for 12 consecutive months or longer. (Bazelton Center for Mental Health, 2001) Without medical coverage, these individuals cannot afford medications to control chronic conditions that may have led to their incarceration in the first place and may contribute to recidivism. This lapse in medical treatment is particularly serious for mentally ill homeless persons, for many of whom jails are the only source of psychiatric care. (Lipton, 2000)

Although states have the authority to terminate Medicaid benefits while an individual is in a correctional facility, federal law does not require them to disenroll incarcerated Medicaid recipients. Instead, states have the option to suspend benefits during incarceration and allow them to be reinstated upon release, following redetermination of eligibility. (Lipton, 2000; Bazelton Center for Mental Health, 2001) To minimize the length of time during which former inmates lack health coverage, advocates are advised to initiate the redetermination process several months before incarceration ends. Pre-release agreements can also be arranged between penal institutions and local Social Security offices to expedite reinstatement of SSI-related Medicaid benefits. (Bazelton Center for Mental Health, 2001)

The persons just described represent significant proportions of the homeless population. Their lack of eligibility for Medicaid coverage seriously restricts their access to comprehensive health care that might enable them to prevent or control acute and chronic conditions that undermine individual well being and threaten the public health.

V. WHY AREN'T ALL ELIGIBLE PERSONS ENROLLED?

A number of recent publications reflect growing concern about the attrition in Medicaid enrollment since enactment of PRWORA. Despite significant expansions in Medicaid eligibility, especially for children and families, there is evidence that Medicaid rolls have diminished in recent years, that uninsured persons are becoming more numerous, and that a portion of the low-income uninsured are eligible for Medicaid but not enrolled. (Ku and Garrett, 2000; Ellis and Smith, 2000; Garrett and Holahan, 2000; Guyer, 2000; Ku and Bruen, 1999) A number of analysts note the following reasons why this commonly occurs:

- **Complex Medicaid eligibility policy** Expansion of Medicaid eligibility beyond categorical minimums in many states and attempts to “de-link” Medicaid from welfare have further complicated Medicaid eligibility policy. Welfare staff retain primary responsibility for educating applicants and beneficiaries about Medicaid application and eligibility requirements, but do not understand the intricacies of Medicaid policy themselves. The objectives of Medicaid and welfare reform (continuous Medicaid enrollment for eligible persons and reducing dependency) overlap in theory but conflict in practice. (Ellwood, 1999)

Confusion about Medicaid eligibility policy results in inappropriate and counterproductive Medicaid terminations. When TANF applications are denied, there is often no mechanism in place to assure a separate determination of Medicaid eligibility, despite federal requirements to do so. Many children and single parents lose Medicaid coverage inappropriately when TANF benefits end. In some states, welfare offices are diverting people to “work first” programs before they even apply for cash assistance, threatening their ability to obtain Medicaid coverage. Advocates in states opting to terminate Medicaid for persons who fail to meet TANF work requirements or to comply with personal responsibility plans report that sanctions are being applied more broadly than is permitted under the law. Ironically, these sanctions undermine the ultimate goal of welfare reform (self-sufficiency through work), for poor health and lack of appropriate health care are major barriers to maintaining employment. (Schlosberg, 1998)

Misunderstanding of Medicaid eligibility requirements deters eligible persons from applying. Frontline eligibility workers are reported to be turning away legal immigrants and even naturalized citizens who seek to apply for benefits, either because of ignorance of the law or outright discrimination. Undocumented aliens are turned away from emergency rooms although they are entitled to emergency Medicaid benefits. (Schlosberg, 1998) A national survey of community health center patients found that 27% of uninsured adults and 70% of uninsured children (an estimated 1.4 million CHC patients in all) were eligible for Medicaid but not enrolled. Confusion about eligibility was a significant factor in decisions not to enroll. (Stuber et al, 2000)

- **Inadequate automated eligibility determination systems** Automated eligibility determination systems have become increasingly inadequate as Medicaid eligibility criteria have become more various and complex, in part because these systems are primarily designed for welfare rather than Medicaid programs. Information system changes to enable faster, more accurate eligibility determination are not a priority for welfare agencies, which tend to control the information systems that are used to determine eligibility for Medicaid and other benefits. Medicaid agencies must often instruct staff to intervene manually in the eligibility determination process because the state’s automated system has not yet been reprogrammed to reflect new Medicaid eligibility rules. Reliance on manual changes increases the risk of error, especially when eligibility workers are new or inexperienced, as is often the case. A supervisor in California reported that “it takes a year before a new staff person can handle routine Medicaid cases independently, and longer for more complicated cases.” The staff turnover rate in many states is

high because of low pay and high Medicaid case loads. (Ellwood, 1999)

- **Complex rules and procedures** Incremental health care reforms during the past decade have resulted in multiple and complex pathways to Medicaid eligibility for different populations, creating extreme difficulty for Medicaid applicants and eligibility workers. For example, the California Medicaid program covers nearly 100 different groups, each with distinct eligibility rules (Ellwood, 1999). Ironically, while rules and procedures have been simplified for higher-income beneficiaries, particularly for pregnant women and children, they have become more complex for other vulnerable populations including disabled people, immigrants and single adults living below the poverty level. (Schlosberg, 1998) Among reported complexities that deter enrollment are:
 - **Different poverty-related income thresholds** for categorical Medicaid and expanded Medicaid/SCHIP programs, often affecting children within the same family;
 - **Lengthy application forms** for multiple benefits, precluding application for Medicaid only;
 - **Confusing rules** for determining “medically needy” status and satisfaction of “spend-down” requirements for different eligibility groups;
 - **Burdensome documentation requirements** for determination of initial eligibility and redetermination of continued eligibility. (Ellwood, 1999)

Community health center patients who perceive the Medicaid application as long and complicated, or report confusion about who can apply, are nearly twice as likely to be eligible but not enrolled as those who do not perceive these barriers. (Stuber et al, 2000)

- **Ineffective communication** Medicaid applicants and beneficiaries suffer from a paradoxical combination of information overload and inadequacy. Notices requesting information, reporting approval or denial of applications, or announcing termination from the program may not be issued in a timely manner or at all. Mailed notices may not be received by the persons for whom they are intended. Even when received, they are often intimidating or incomprehensible to recipients. (Ellwood, 1999) Misinformation and confusion about Medicaid rules have become major barriers to low-income immigrants, whose participation rates have sharply declined. Not all forms, brochures and notices get translated into languages spoken by recipients, and bilingual staff or interpreters are not always readily available. (Ibid.) Language barriers and fears that receipt of Medicaid benefits will disqualify them from becoming citizens deters many immigrants from applying for eligible children. (U.S. GAO, 1998) Hispanic patients in community health centers are three times more likely to be eligible but not enrolled than white patients, but are significantly more likely to report immigrant fears, lack of translators, and ignorance about how to apply as barriers to enrollment. (Stuber, et al, 2000)
- **Negative attitudes of some eligibility workers and service providers toward Medicaid applicants and beneficiaries** To the extent that stigma is a barrier to Medicaid enrollment, it is a function of how people are treated during the application process and by health care providers, rather than how beneficiaries feel about themselves or the program when they participate in Medicaid. (Stuber, et al, 2000) For example, being required to answer “unfair” personal questions during the application process and the perception that providers do not treat those on Medicaid equal to people with private health insurance are significant deterrents to enrollment. Of community health center patients surveyed in 1998, 35% reported that the Medicaid application process is humiliating. Persons who apply for Medicaid at places other than a welfare office are much less likely to report treatment stigma associated with the application process. These findings strongly support increased emphasis on outstationing and alternative enrollment sites. (Ibid.)
- **Lack of outreach to persons likely to be eligible** Aggressive outreach and informing efforts by Medicaid agencies in community-based settings are still lacking, despite pervasive confusion

about eligibility and benefits. Outstationing of eligibility workers in sites where persons who are likely to be eligible for Medicaid receive health services is one way in which Medicaid agencies can facilitate enrollment. *Under HCFA regulations, unless a State has demonstrated to HCFA that it has an equally or more effective alternative plan for outstationing, State Medicaid programs are required to provide outstationed eligibility workers (OEWs) at each Federally Qualified Health Center (FQHC) participating in the State's Medicaid program that is frequently used by pregnant women and children.* (HCFA, 2001)

As of April 2000, 67% of all FQHC grantees (23% of all FQHC sites) had OEWs. In only six states (Arkansas, Indiana, New Jersey, Oklahoma, Utah and Wisconsin) was implementation of outstationing requirements judged by the state Primary Care Association and FQHCs to be satisfactory —i.e., at least 100% of FQHC grantees in the state have a state-financed OEW. Thirteen states (Kentucky, Louisiana, Minnesota, Nebraska, Nevada, New Hampshire, New Mexico, North Dakota, Pennsylvania, South Dakota, Virginia, West Virginia and Wyoming) had no OEWs in FQHCs. (HRSA, 2000) Of course, successful outstationing presupposes the availability of eligibility workers who are knowledgeable about Medicaid policy and sensitive to the needs of applicants.

- **Faulty redetermination procedures resulting in premature or inappropriate termination of coverage** Several groups of Medicaid beneficiaries are being prematurely or inappropriately terminated, contrary to federal law. State Medicaid agencies have the following obligations to beneficiaries who no longer meet requirements for eligibility under one category:
 1. *The state must conduct a prompt ex parte determination of eligibility* —that is, assessment of whether the beneficiary qualifies for any other eligibility category in the State's Medicaid plan.
 2. *The state must protect the beneficiary's due process rights while an ex parte determination is pending, including the right to a hearing and continuation of coverage until a decision is rendered.*
 3. *If the redetermination process results in a finding of ineligibility, the state must provide recipients with timely and adequate notice of the proposed action to terminate coverage.*
 4. Recipients may be able to get services reinstated, even if they failed to request a hearing before the date of action. If the recipient requests a hearing more than 10 days after the date of action, *the State Medicaid agency may reinstate services if "just cause" is given for failure to meet the appeals deadline*—e.g., if a physical or mental disability makes it difficult for the recipient to understand the termination notice or to respond to it in a timely fashion, or if the recipient's whereabouts were unknown before the date of action but become known during the time he/she is eligible for services. (Schlosberg, 1997)

There is ample evidence that in several states, persons losing SSI eligibility because an alcohol or drug disorder is material in the determination of disability have not been given an *ex parte* determination as required by law. Persons whose disabilities are not sufficiently severe to satisfy the federal definition or whose income and assets exceed SSI thresholds may qualify for health coverage under another Medicaid eligibility category in some states. The same is true for parents losing TANF-Medicaid who are eligible for transitional Medicaid, and for their children, most of whom remain eligible for Medicaid and/or SCHIP programs. (Ibid.)

Reports from homeless service providers suggest that many of the enrollment barriers just summarized are even more pronounced for persons experiencing homelessness. The following analysis identifies deterrents to Medicaid enrollment that affect homeless persons disproportionately, if not uniquely, and tells what Health Care for the Homeless projects around the country are doing to help overcome them

VI. ENROLLMENT BARRIERS FOR ELIGIBLE HOMELESS PERSONS

The National Health Care for the Homeless Council surveyed 33 federal Health Care for the Homeless grantees in November–December 2000, to determine what Medicaid enrollment barriers, if any, their homeless clients were encountering. Recipients were asked to select a direct service provider in their project experienced in Medicaid application or enrollment assistance (e.g., a case manager) to complete the survey with input from all social service staff.

METHODS

A copy of the survey used, developed in consultation with the National Council's Medicaid Reform Committee, organizational members and staff, is included in Appendix A. The survey began with a request to estimate the number and percentage of homeless clients seen during the past year who were probably eligible for Medicaid but not enrolled. Estimated rather than actual numbers were initially requested, with the expectation that most HCH projects were not currently tracking homeless Medicaid applicants, nor did they yet have systems in place to do so. Seven projects subsequently agreed to submit actual numbers of uninsured homeless clients in categories that made them likely to be eligible for coverage. Their findings are included in the analysis that follows.

Survey recipients were also asked to rate the comparative seriousness of particular Medicaid enrollment barriers for their clients. Potential obstacles presented for evaluation were cited as commonly experienced by homeless and other medically underserved populations in the recent literature or by homeless service providers consulted by the National Council.⁸ Persons completing the survey were instructed to rate the extent to which each specified barrier was a problem for their homeless clients, on a scale of 1 to 5. Levels of seriousness were defined as follows:

- 5 = *very serious* – prevents large numbers of clients from enrolling each year
- 4 = *serious* – significant problem for clients on a regular basis
- 3 = *moderately serious* – frequently encountered by a few clients
- 2 = *minor problem* – occasionally encountered but fairly easily resolved
- 1 = *not a problem* – rarely or never encountered by clients
- 0 = *not applicable* to our organization

Enrollment barriers to be rated were grouped within four general categories explaining lack of Medicaid coverage: *failure to apply*, *applied but never enrolled*, *coverage denied* or *disenrolled*. Homeless service providers were also asked to list other obstacles to enrollment their clients had experienced.

Next, the survey questioned homeless service providers about their efforts to facilitate Medicaid enrollment for homeless people. Recipients were asked whether the following services are provided on site:

- Eligibility determination by outstationed eligibility workers
- Presumptive eligibility determination for pregnant women and/or children
- Medicaid benefits counseling, referral or application assistance

Respondents were also given the opportunity to report other services that their project provides to reduce Medicaid enrollment barriers. Finally, HCH projects were asked to specify what would help them to get more homeless people on Medicaid.

⁸ The bibliography at the end of this report and experienced homeless service providers were consulted in developing the list of potential Medicaid enrollment barriers which surveyed HCH projects were asked to rate.

RESULTS

Thirty-three (37%) of the 89 HCH projects contacted returned a completed survey. Survey respondents are listed in Appendix B. Tables 3–8 and subsequent analyses in Appendix C summarize their responses. Eight of these projects contributed more detailed quantitative and qualitative information about the barriers to Medicaid enrollment that homeless people in their area encounter. Brief synopses of this information appear on pages 26–30; detailed analyses are contained in Appendix D.

SUMMARY OF FINDINGS

What did we learn from surveyed Health Care for the Homeless grantees about why apparently eligible homeless persons do not have Medicaid coverage, how large a problem this is for HCH project users, and how identified enrollment barriers can be reduced or eliminated?

Pervasiveness of the problem Failure to enroll in Medicaid despite likely eligibility affected 10–50% of homeless clients seen by over half of survey respondents during the past year. This amounted to about 200–900 individuals per project, or a total of close to 17,000 clients who might have qualified for Medicaid but remained uninsured. The variance is explained by differences in numbers of homeless clients served and the proportion of these clients who were categorically ineligible for Medicaid under current state policy.

Who falls through the cracks? Survey respondents identified four groups of homeless people who are mostly likely to be uninsured but Medicaid eligible:

- **Families** that lose or never receive TANF benefits and do not apply or reapply for Medicaid/SCHIP for their children, or do not receive transitional Medicaid when wages exceed income thresholds for TANF-Medicaid;
- **Emancipated and unaccompanied minors** who fail to apply for Medicaid after separating from their families, after leaving state custody or following juvenile detention;
- **Children of unqualified immigrants** who fail to enroll their qualified children in Medicaid/SCHIP for fear of being reported to the Immigration and Naturalization Service; and
- **Individuals with functional impairments** that may qualify them for disability-based Medicaid who fail to meet documentation requirements or keep appointments for consultative examinations with DDS claims examiners and physicians. Initiation and completion of the complex enrollment process is especially difficult for homeless persons with severe mental illness, for whom denial of illness and paranoia are often symptoms of their impairment.

Although women, children, and severely disabled persons do not comprise the largest proportions of homeless clients served by most HCH projects, as many as half of respondents rated enrollment barriers for these particular groups as “serious” or “very serious.”

Homeless persons who qualify for Medicaid in one state but move to another are among those most likely to be eligible but unenrolled. Obtaining required documentation to verify eligibility (birth certificates, proof of income and residence, etc.) is especially difficult for those who are fleeing domestic violence and suffering from physical and emotional trauma.

Impediments to enrollment According to all survey respondents, the proximate reasons why homeless persons across all eligibility categories do not apply, enroll or maintain continuous enrollment while eligible are:

- *Misunderstanding of Medicaid enrollment criteria* (didn't think they were eligible);
- *Failure to complete the enrollment process* following application (e.g., missed face-to-face interview);
- *Failure to obtain required documentation* to verify or reverify eligibility; and
- *Missed communications* from the Medicaid agency about enrollment or termination due to the lack of a permanent mailing address or a third-party contact.

Virtually all respondents agreed that the following enrollment barriers prevent homeless persons who are eligible for Medicaid from obtaining or maintaining coverage:

- Ignorance or misunderstanding of eligibility criteria discourages many from applying in the first place.
- Missing contact information on the application form, failure to obtain required documentation, and failure to follow up prevent many who do apply from enrolling.
- Of those who manage to enroll, many are disenrolled at the time of reverification or redetermination for failure to receive or respond to reverification notices, or to present documentation confirming their continued eligibility.

This is not surprising, given the complexity of Medicaid eligibility criteria and the reported inconsistency of enrollment procedures, compounded by the mobility of people living in crisis.

More than half of respondents reported that homeless clients served during the past year who were expected to qualify for Medicaid

- failed to apply because of impaired capacity to apply or because they thought they weren't eligible;
- applied but never enrolled because contact information was missing on their application and mail was undeliverable, because they failed to follow up after the application, or because they had a problem meeting verification requirements;
- were disenrolled because they failed to receive or respond to the reverification notice or did not present required documentation for reverification.

Other enrollment obstacles When asked to identify other enrollment obstacles not specified in the survey, respondents tended to address ultimate reasons why eligible homeless people do not enroll or remain enrolled in Medicaid—that is, reasons that explain the enrollment barriers specified in survey questions. They pointed to two sorts of problems that deter enrollment for homeless people: system inadequacies and problems associated with homelessness.

System inadequacies Most of the system inadequacies identified were associated with application and eligibility determination processes—lengthy and complex enrollment procedures, excessive documentation requirements, poorly trained and insensitive eligibility workers, and lack of accommodation for non-English speakers and persons with educational and functional limitations. Systems barriers most frequently mentioned were complexity of the application process, lack of eligibility determination at homeless service sites, and erroneous or incomplete information about eligibility due to poorly trained eligibility workers with high turnover rates. Obstacles presented by Medicaid offices include the lack of interpreters and bilingual intake workers, and the “dehumanizing attitude” of eligibility workers.

Lack of reasonable accommodation for severely disabled clients, an insufficient number of agencies assisting with SSI applications, lack of available physicians to determine medical disability, and application forms that fail to elicit needed information from providers were listed as impediments to

enrollment for homeless clients with disabling conditions. State outreach efforts, case management and entitlement assistance from shelter staff (which might have alleviated some of these system inadequacies) were found to be either lacking or insufficient. The lengthy eligibility decision making process and inaccessible providers under managed care were listed as further deterrents to enrollment for homeless people.

Problems associated with homelessness Proof of identity, residence and income is difficult to come by for people without a home or a car or continuous employment. Obtaining required documentation is often costly, time-consuming and intimidating, and homeless people may have no safe place to keep it, once it is obtained. Personal papers are often stolen or lost in moving from place to place on foot. Lack of required documentation to verify eligibility was the most frequently cited Medicaid enrollment obstacle for homeless people.

Mental illness and substance abuse, lack of transportation, transience, and educational and functional limitations were also identified as problems characteristic of homeless clients. Lack of resources to renew a Medicaid application (i.e., obtain required documentation), inability to pay outstanding premiums from a previous eligibility period prior to homelessness, and unaffordable co-payments may be insurmountable financial barriers for impoverished people who are homeless.

Mistrust of government programs from past experience, and fear of public officials who may be associated with law enforcement efforts to drive homeless people from the area also explain their reluctance to apply for entitlements. Finally, persons experiencing homelessness may be intimidated by paperwork (especially if they are illiterate or don't speak English), they may not understand the benefits of Medicaid coverage, or may fail to complete the enrollment process because they are unaware that their application has been approved.

Overcoming enrollment barriers Survey respondents repeatedly emphasized that without aggressive application assistance, client advocacy and follow-up by homeless service providers, significant numbers of eligible homeless persons remain uninsured even in states with expanded eligibility criteria and willingness to accommodate populations with special needs. With such assistance, as many as 10–30% of uninsured clients served by some HCH projects might obtain Medicaid coverage, according to special reports by seven survey respondents. Nevertheless, despite these efforts, a number of homeless applicants are lost to follow-up when they move before eligibility determinations are made, or before applications that are inappropriately denied can be appealed. These problems are of sufficient complexity that they require joint efforts of multiple stakeholders at the federal, state and community levels to solve.

The survey explicitly asked homeless service providers whether or not they are providing the following services to facilitate Medicaid enrollment:

- **Outstationed eligibility workers.** Availability of Medicaid eligibility workers at sites where homeless services are provided was repeatedly cited as an important means of facilitating enrollment. As noted, State Medicaid agencies are required to provide on-site eligibility determination at all Federally Qualified Health Centers that are frequently used by pregnant women and children. Currently, 45 Health Care for the Homeless projects (33%) serve families and children. Forty-one percent of respondents to this survey reported that on-site eligibility workers are available at their projects—in Arizona, California, Florida, Illinois, Minnesota, Missouri, New Mexico, Pennsylvania, Texas and Utah. (In Iowa, as in some other states, the HCH project is affiliated with a Community Health Center that has an eligibility worker.)
- **On-site presumptive eligibility determination for pregnant women and/or children.** Less than half of respondents said that HCH project staff determine presumptive Medicaid eligibility—in

California (3 sites), Connecticut, Illinois, Missouri, Montana, New Mexico, Oklahoma, Oregon, Pennsylvania, Texas, Utah, Wisconsin and Wyoming.

- **Medicaid benefits counseling, referral or application assistance.** Nearly all respondents said they provide these services to homeless clients. Application assistance includes client education about entitlements, provision of applications, and assistance filling them out.

In addition to the types of assistance listed above, some federal HCH grantees reported a number of other services they provide to reduce Medicaid enrollment barriers. These include:

- **Case management** and education of homeless clients about HMO assignment;
- **Staff training** in entitlement assistance at community-based organizations;
- **Identification of clients likely to be eligible**, application assistance and follow-up;
- **Provision of medical evaluations** and assistance with disability determination;
- **Entitlement outreach to homeless people** in area shelters and soup kitchens;
- **Individual advocacy** to help homeless clients negotiate Medicaid managed care systems;
- **Policy advocacy** to expand Medicaid eligibility for single adults with disabilities.

How to get more homeless people on Medicaid Finally, surveyed federal HCH grantees were asked to specify what would help them get more homeless people on Medicaid. Following is a summary of their responses:

Implementation and enforcement of current policy:

- Outstationed eligibility workers and benefits counselors in more homeless service sites;
- Presumptive eligibility for homeless children in all states;
- Expansion of coverage to parents of Medicaid eligible children.

Policy changes:

- Expansion of Medicaid eligibility to include all homeless persons;
- Less rigid time and documentation requirements for verification/reverification of eligibility.

Systems changes – improved application/certification process:

- SSI-Medicaid eligibility determination systems changes;
- Shorter eligibility determination process;
- Dedicated Medicaid office for application, follow-up and reverification;
- More eligibility workers, smaller case loads;
- Improved administrative coordination and simplicity;
- Transportation assistance for homeless applicants required to have face-to-face interviews;
- Authorization of outreach workers to assist clients with application process;
- HCH project access to patient eligibility status in the Medicaid database;
- Handouts explaining Medicaid eligibility in simple language.

Improved treatment of homeless applicants:

- More positive attitudes of government workers toward persons seeking entitlements;
- Faster, more sensitive response to applicant inquiries.

Funding assistance:

- to support intensive case management;
- to obtain required documentation (e.g., birth certificates);
- to enable more application assistance by project staff;
- to increase capacity for administrative advocacy to speed Medicaid expansions.

Improved education about Medicaid requirements and procedures:

- for entitlement workers;

- for application assistance staff;
- for homeless people.

Additional Information from Eight HCH Projects

Eight survey respondents from seven different states provided more extensive qualitative and/or quantitative information that helps to explain why homeless people who are ostensibly eligible for Medicaid fail to enroll. Many of these reports, briefly summarized below, also show what homeless service providers and advocates are doing to facilitate enrollment and continued coverage for eligible homeless persons. More detailed accounts appear in Appendix D.

KENTUCKY

Family Health Centers, Inc., HCH Project in Louisville-Jefferson County, Kentucky, tracked homeless patients seen in FY 2000 by physicians or nurse practitioners in HCH-funded service sites. They reported that 95% of these patients had no health insurance in FY 2000. Most of those with Medicaid coverage (only 4% of all homeless patients) were children or adults with dependent children. *Although nearly all children served should have qualified for the state's Medicaid managed care program (Passport), 88% were uninsured, representing 10% of all uninsured clients served by the project.* This discovery prompted HCH coordinator Bart Irwin to remark, "There needs to be a greater effort on the part of the HCH project to discover why potentially eligible children are not receiving Medicaid benefits."

Of all adults with dependent children served, 91% were without health insurance. They tended to be from out of state, eligible for but not receiving TANF, or no longer eligible for TANF because of increased earnings. Many of these individuals should also have qualified for Medicaid. The vast majority of homeless service recipients at FHC are single adults whose only option for health coverage is through SSI-related Medicaid. Three percent of homeless adults not in families who have Medicaid or Passport qualify because of disabling physical or mental illnesses.

MASSACHUSETTS

The Boston Health Care for the Homeless Project tracked homeless Medicaid applicants seen by the agency over a three-year period, between July 1, 1997 and July 31, 2000. They calculated application approval and denial rates, and examined the extent to which clients who qualified for Medicaid were able to remain on the program following the annual eligibility review. They found that 22% of applications initially denied were subsequently approved, and that 6% of beneficiaries whose coverage was initially terminated were reinstated after aggressive follow-up and advocacy by HCH case managers. As a result, *824 more homeless clients (approximately 20% of uninsured patients during that period) had Medicaid coverage than would have qualified without these efforts.*

Eligibility was determined when homeless clients whose mail had been returned were located, when missing information on the application was completed, when eligibility review forms were completed and returned, and when processing errors were identified and corrected. "Despite the best intentions of a state that advocates describe as being highly committed to enrolling homeless people in Medicaid and serving them well, significant numbers of eligible persons do not qualify for coverage without aggressive follow-up and advocacy by homeless service providers," remarks BHCHP executive director Bob Taube, PhD.

Boston HCH also reported impediments to SSI disability assistance for homeless people identified by the Homeless Subcommittee of the Massachusetts Division of Disability Services (DDS) Advisory Committee. This workgroup, whose members include DDS homeless claims examiners, consumers and advocates, identified the following barriers that homeless claimants face in applying for SSI disability benefits: 1) failure to list addresses and phone numbers of all medical providers on disability claims, 2) insensitivity of some SSA intake workers to homeless applicants with mental or behavioral disorders, 3) failure of claimants to specify a third-party contact (with a stable address) to facilitate claims processing, and 4) eligibility decisions that occur after homeless claimants leave shelters without a forwarding address.

Of disability claims filed by homeless persons in Boston, 9/1/98–5/31/99, more than twice as many were denied than allowed, and the allowance rate for homeless claims was lower than the average allowance rate for all disability claims during that period. Failure to keep appointments for consultative examinations, insufficient medical evidence, and failure to follow prescribed substance abuse treatment accounted for 47% of denied homeless SSI claims. Advocates note that with aggressive application assistance, advocacy and case management, many of these denials might have been reversed. (*Although disabled persons in Massachusetts can qualify for Medicaid without applying for SSI, these findings may be of interest to states in which Medicaid eligibility for disabled persons is linked to SSI.*)

HCH Mercy Hospital in Springfield, Massachusetts tracked approvals and denials of Medicaid applications in FY 2000. Coverage was approved for 71% of homeless applicants and denied for 29%. Half of those denied were lost to follow-up, precluding discovery of the reasons for denied coverage. Among reasons for denial that could be ascertained was failure to meet the minimum financial or employment standards for eligibility under the state's expanded Medicaid program. The HCH project reports that it experiences no difficulty getting homeless women or children under age 19 enrolled in Medicaid. Those who remain uninsured are primarily single adults failing to demonstrate eligibility for the state's Medicaid demonstration program, MassHealth, under which adults who have not worked during the past year or make less than \$3,000 and disabled persons under 133% FPL may qualify for health coverage. (*See Appendix D for more details.*) Qualifying for Medicaid and disability assistance under the federal SSI program is more complicated than under MassHealth, often requiring comprehensive documentation of *all* co-occurring mental and physical problems to demonstrate disability. "Separately, clients' problems may not qualify them for disability assistance, but they may qualify when all disabling conditions are taken into consideration," explains program manager Judith Mealey, NP.

NEW HAMPSHIRE

The Mobile Community Health Team Project at Catholic Medical Center in Manchester, New Hampshire, *identified 14% of all uninsured homeless service users in FY 2000 who were potentially eligible for Medicaid but not enrolled.* Of these clients, 1% were children under age 17, 26% were adolescents ages 17–18, 18% were youth ages 19–24, and 55% were adults ages 25–64.

All homeless children under age 19 with income up to 185% FPL are eligible for Poverty Level Medicaid in New Hampshire. Teens aged 17–18 who may have separated from their families are now considered distinct, one-person households or family units whose poverty level is based on their own income or lack thereof, not upon their parents' income. "This is often a source of great confusion for Medicaid eligibility workers," reports homeless health care coordinator Marianne Feliciano, BSN, RN. Moreover, "runaway" and "throwaway" adolescents and youth typically do not apply for Medicaid after separating from their families or following release from juvenile detention or prison.

Such youth often remain fearful and suspicious of social service agencies, and, like most adolescents, generally are not cognizant of their own health needs.

Homeless adults (age 19 and above) may qualify for Medicaid only in conjunction with pregnancy or a disability. Some seniors (over 65) who are dually eligible for Medicare and disability-based Medicaid lose Medicaid eligibility if their income rises, ever so slightly, with a Social Security Pension. To re-qualify under the Medicaid spend-down program, they must disclose income and assets and endure a lengthy application process. Most clients are reluctant to do this. Caseworkers report that the Medicaid application process is so cumbersome that some clients see it as “not worth the struggle.”

NEW YORK

Care for the Homeless New York City shared results of a study on Barriers to Medicaid, conducted in collaboration with the Commission for the Public’s Health System and the Greater Upstate Law Project. (Care for the Homeless, et al, 2001) The study identifies impediments to enrollment reported by recent Medicaid applicants and application assistance providers in community-based service sites. About one-third of targeted applicants were homeless. The authors specify 11 enrollment obstacles inherent in the application and certification process that the State of New York has the power to change:

- lengthy, poorly designed application form
- language-appropriate forms and application assistance below federal standards
- excessive documentation requirements
- assets test requirement
- personal interview requirement
- finger-imaging requirement
- alcohol & drug screening and treatment
- prerequisites
- inconsistent documentation requirements and practices
- eligibility determination process exceeding federal time limits
- lengthy, too frequent recertification process
- required reapplication for residents moving to another district

Virtually all of these barriers are state created rather than federally mandated, they argue, resulting from statutory, regulatory and procedural discrepancies between the New York State Medicaid program and federal Medicaid program requirements and guidance to states. State Medicaid regulations impose major, legally unnecessary barriers to Medicaid coverage for both applicants and recertifying beneficiaries, they contend. (Ibid.; Steinhauer, 2000) For example, federal and state Medicaid laws specify only one documentation requirement to verify eligibility, while New York State Medicaid agency regulations prescribe 20.

The report provides vivid illustrations of the frustrations that dissuade homeless persons from completing the Medicaid application and enrollment process, explains how these enrollment barriers are severely restricting access to health coverage for eligible populations, and recommends state legislative and administrative actions to remove them.

TENNESSEE

The Homeless Health Care Center in Chattanooga tracked homeless clients seen in FY 2000 who were not enrolled in TennCare, Tennessee's 1115 Medicaid demonstration program. Case manager Jord Field predicts that *35% of clients not on TennCare in FY 2000 (20% of all clients seen) might have enrolled with comprehensive application assistance.* Among persons who may qualify for TennCare are children under age 19 with family income below 200% FPL, and medically vulnerable individuals ("uninsurables") of any age or income who are denied private insurance because of a pre-existing medical condition.

Homeless service providers report that disenrollment following reverification of eligibility is a bigger problem for homeless children than their initial enrollment in TennCare. Of homeless children seen by the clinic in FY 2000, 70% were on TennCare and 30% were previously disenrolled for failure to respond to a reverification notice, or when parents lost TANF and failed to reapply for TennCare for their children. All uninsured children would have qualified for TennCare, had they applied.

Adult applicants were denied coverage for having health insurance in another state, or past-due TennCare premiums (if income exceeded 100% FPL) due to failure to report changes in income after becoming homeless, or for failure to obtain a letter from a private insurer denying coverage for an "uninsurable" condition. Field estimates that with comprehensive assistance, 27% of uninsured homeless adults seen in FY 2000 might have qualified for TennCare. "Comprehensive assistance" includes paying \$25 per client to obtain letters of denial from private insurance companies, negotiating reconsideration of errors made in the eligibility determination process, and helping clients obtain required documentation for enrollment or reverification.

The TennCare Shelter Enrollment Project, conducted by the National Health Care for the Homeless Council since July 1998, educates emergency shelter providers across the state to facilitate the enrollment of eligible homeless children in TennCare and monitor their access to primary care. Among the enrollment barriers identified by families residing in 35 participating homeless and domestic violence shelters are: ignorance of eligibility criteria, difficulty filling out applications and providing required documentation, missed communications about eligibility determination and enrollment, difficulty obtaining transportation to face-to-face interviews, and long delays between application and enrollment.

The project has been instrumental in reducing these barriers by educating shelter providers about TennCare, by convincing health departments in several counties to offer expedited (same-day) enrollment for homeless children, and by convening community-based workgroups to identify and address enrollment and health care access barriers on an ongoing basis. Workgroup participants include shelter providers, representatives of state agencies and managed care organizations, health care providers, and homeless families. As a result of these and other outreach efforts, only 3% of homeless children were uninsured at discharge from participating shelters last year.

TEXAS

Community Health Care of Lubbock, Texas examined electronic encounter data to determine the number of homeless clients lacking Medicaid coverage who had medical diagnoses suggesting that they were probably eligible for SSI-Medicaid. *Of 1,770 homeless clients lacking health insurance in FY 2000, nearly one-third (31%) had disabilities that should have qualified them for SSI-Medicaid,* reports homeless health care coordinator Sue West. These included severe mental illness and severe physical disabilities secondary to diabetes and kidney problems.

WISCONSIN

Health Care for the Homeless of Milwaukee, Inc. tracked uninsured homeless clients seen in FY 2000 who were likely to qualify for Medicaid. Of 6,072 clinic patients seen that year by HCHM, 85.1% were uninsured. *Providers identified 638 (12%) of these uninsured patients who were probably eligible for Medicaid though not enrolled.* Approximately 6% of these patients had severe and persistent mental illness, 78% had other chronic medical conditions that might qualify them for SSI-Medicaid, and 16% had lost benefits due to welfare reform (when they lost TANF).

“Clients who apply for SSI-Medicaid are usually successful if they are working with a case manager, but not as successful if they apply on their own,” reports executive director Lee Carroll, MSW. Homeless health care providers at HCHM agree that the SSI application process is too lengthy, and the application form is too long and complex. Understanding eligibility requirements is difficult even for case managers. Meeting medically needy standards for spend-down Medicaid is also complex, and requires an advocate to assist homeless persons.

“Welfare reform in Wisconsin created some confusion with regard to Medicaid eligibility,” notes Carroll. “When custodial parents lost TANF-Medicaid, they were unaware of their children’s continued eligibility under Medicaid, regardless of their own. There was also confusion about eligibility requirements for children and custodial parents under BadgerCare, Wisconsin’s 1115 Medicaid demonstration program that includes the Title XXI (SCHIP) eligibility expansion for children and the Title XIX eligibility expansion for adults.”

DISCUSSION

Data limitations Data and impressions just summarized were provided by only 24% of 135 federal Health Care for the Homeless grantees in year 2000. The survey was sent electronically to 89 projects with known e-mail addresses (66% of all federal HCH grantees), and was completed by 33 of them. This was not a probability sample, randomly selected. Thus respondents cannot reliably be said to represent all federal HCH grantees, much less all homeless service providers in the United States, in their assessment of Medicaid enrollment barriers for homeless people. Nevertheless, survey respondents comprise a fairly diverse, though self-selected subset of homeless service providers. Collectively, they represent most regions of the United States, both stand-alone and CHC-affiliated HCH projects, serving homeless populations large and small, urban and rural, in states with traditional categorical and/or expanded Medicaid programs. Twenty respondents are organizational members of the National Health Care for the Homeless Council and 12 are not. In these respects, the sample represents an interesting cross-section of homeless service providers and the clients they serve.

Survey respondents confirmed that most HCH projects do not routinely track the insurance status of homeless clients likely to qualify for Medicaid to determine why applicants fail to enroll or why clients who do enroll have their benefits terminated. This limited the number of respondents who were able to provide detailed data demonstrating actual numbers of eligible homeless clients lacking Medicaid coverage who benefited from aggressive client advocacy. Nevertheless, the primary purpose of this survey was not rigorous quantification of all homeless persons known to be eligible for Medicaid though not enrolled. Nor was the survey designed to determine exact numbers of homeless persons experiencing particular enrollment barriers. Such goals were beyond the scope of this inquiry and beyond the capacity of most HCH projects to ascertain. Indeed, few municipal or

state Medicaid agencies track homeless applicants and beneficiaries, despite their far greater capacity to do so.

Rather, our intent was to learn why only 20% of HCH clients, on average, are on Medicaid. (BPHC, 1999) We also wanted to identify the most serious enrollment obstacles homeless people are encountering from the perspective of a cross-section of experienced homeless providers nationwide. Finally, we hoped to learn how HCH projects are helping homeless clients to surmount these obstacles or remove them altogether, and what in their judgment would enable more homeless people to qualify for Medicaid. From this information, we hoped to derive recommendations for all homeless service providers and public health policy makers.

As the published literature confirms, many of the enrollment obstacles homeless people face are also experienced by other vulnerable populations, though perhaps not to the same extent. It is clear from survey results that the transience inherent in homelessness poses special challenges to centralized application and verification processes, as does the high prevalence of mental and behavioral health disorders and other disabling conditions among homeless people.

Study limitations It would be disingenuous to focus on enrollment system inadequacies and obstacles intrinsic to homelessness without acknowledging the main reason why more homeless people are not enrolled in Medicaid—restrictive eligibility criteria. It is evident that the number and percentage of HCH clients who are uninsured significantly depends on the extent to which the states in which they live have implemented expanded Medicaid eligibility criteria, particularly for single adults, who make up the vast majority of homeless service recipients.

Even if all identified enrollment barriers were eliminated, a majority of clients seen by surveyed HCH projects would probably remain uninsured because they do not qualify for coverage under current Medicaid policy. To focus too narrowly on improving flawed systems is counterproductive.

It is clear to experienced homeless providers and advocates that far too much effort is expended in this country trying to keep “unworthy” people from obtaining public health insurance, and that not enough resources and energy are devoted to increasing access to comprehensive health care.

VII. CONCLUSIONS

Continued devolution of responsibility for Medicaid policy from the federal government to the states has resulted in a fragmentary system of health coverage and health care for the nation's most vulnerable people. Despite good intentions, there is growing evidence that incoherence and extreme administrative complexity are making the Medicaid program virtually inaccessible to many of its intended beneficiaries. An unforeseen consequence of eligibility expansions in recent years is that in some jurisdictions, lower financial capacity entails a higher burden of proof of eligibility, resulting in further barriers for homeless applicants.

Implementation of federal Medicaid policy at the state level is where things get especially complicated. (See *Care for the Homeless, 2001* for examples of legally unnecessary obstacles to Medicaid coverage for both applicants and recertifying beneficiaries, imposed by a state Medicaid agency.) Homelessness exacerbates the difficulties poor people typically experience in completing Medicaid application and enrollment processes, and in meeting requirements for continued coverage, once enrolled.

These are among the conclusions that may be drawn about the effects of homelessness on Medicaid enrollment and why apparently eligible homeless persons are not enrolled:

- 1. Homeless persons who may be eligible for Medicaid but are not enrolled tend to fall within one or more of the following categories:**
 - Children with a parent who has lost TANF
 - Emancipated and unaccompanied minors
 - Immigrant children born in the United States
 - Children enrolled in a SCHIP program bypassing application for Medicaid
 - Women no longer on welfare (TANF)
 - Women with dependent children meeting medically needy limits
 - Women diverted into a "work first" program bypassing application for TANF-related Medicaid
 - Persons with severe mental illness or disabling medical conditions
 - Persons losing SSI because of an alcohol or drug disorder who have other qualifying conditions
- 2. The most serious and pervasive obstacles to Medicaid enrollment for homeless people across all eligibility categories are:**
 - Confusion about eligibility;
 - Missing address/phone number where they or a designated third party can be contacted to receive information from the Medicaid agency;
 - Lack of required documentation of identity, state residence, income and assets to confirm eligibility; and
 - Failure to complete the enrollment process following application.
- 3. Inappropriate disenrollment is a serious problem for homeless beneficiaries who**
 - do not receive redetermination notices because of difficulty receiving mail;
 - have difficulty providing required documentation to verify continued eligibility;
 - lose benefits in violation of their due process rights under federal law.
- 4. Failure of eligible homeless persons to obtain Medicaid coverage is a function of system inadequacies, conditions inherent to homelessness, and actions by State Medicaid agencies and their contractors.**

System inadequacies that deter eligible homeless people from enrolling in Medicaid:

- Lack of outreach by Medicaid agencies to persons likely to be eligible;
- Ineffective communication of information about eligibility and the application/enrollment process to intended beneficiaries;
- Confusion of eligibility workers about who is eligible;
- Excessively long and personally intrusive application forms;
- Lengthy application processes and delayed eligibility determination;
- Negative attitudes of eligibility workers and health care providers toward applicants and beneficiaries.

Conditions inherent to homelessness that deter Medicaid enrollment of eligible persons:

- High prevalence of mental illness and substance abuse;
- Transience, complicating receipt of communications about eligibility and enrollment;
- Low educational and functional capacity;
- Lives in crisis, relegating the pursuit of insurance and preventive health care to a lower priority.

State actions that deter enrollment of eligible homeless persons:

- Failure of State Medicaid agencies to conduct *ex parte* determinations of eligibility under any other eligibility category in the state plan whenever beneficiaries no longer qualify for one eligibility category;
- Failure of State Medicaid agencies to send a timely notice prior to the date of Medicaid termination when eligibility is lost;
- Termination of benefits by State Medicaid agencies before an *ex parte* determination has been made or an appeals decision rendered;
- Failure of State Medicaid agencies to outstation eligibility workers in Federally Qualified Health Centers;
- Failure of hospitals and other caregivers to provide appropriate Emergency Medicaid benefits or public health services to persons who are eligible for them;
- Requiring information about immigration status by providers as a condition for Emergency Medicaid;
- Sharing information about homeless Medicaid applicants by state agencies and providers with the Immigration and Naturalization Service.

5. Aggressive outreach and advocacy can reduce the percentage of uninsured homeless persons served by some HCH projects by as much as 10–30%. Specific actions by various stakeholders that facilitate Medicaid enrollment include:

- Specification of third-party contacts with a stable address (e.g., a case manager or family member) on application forms to facilitate timely receipt of communications from the Medicaid agency;
- Detailed documentation of all co-occurring mental and medical disabilities and their known duration by homeless health care providers;
- Assistance to applicants for SSI-related Medicaid by securing a representative for homeless claimants, and by assuring that consultative examinations (where required) are conducted by physicians with significant experience in treating homeless patients ;
- Assistance in obtaining required documentation to verify eligibility;
- Assistance in filing appeals when eligibility is inappropriately denied.

VIII. RECOMMENDATIONS

What can homeless service providers, government agencies and elected officials do to facilitate Medicaid enrollment for eligible homeless people? The National Health Care for the Homeless Council proposes the following recommendations, based on evidence provided by surveyed HCH providers and from the current literature:

What agencies serving homeless people can do

Homeless health care providers can

1. Educate homeless clients about Medicaid eligibility criteria, benefits, application/enrollment requirements and procedures, and the right to appeal decisions to terminate their eligibility.
2. Encourage homeless clients to list third-party contacts (i.e., persons with a stable address authorized to receive communications on their behalf) on all Medicaid applications and to list provider contact information on SSI applications.
3. Assist homeless applicants in obtaining required documentation to verify eligibility.
4. Facilitate applications for SSI-related Medicaid by keeping detailed records of all impairments, by developing a working relationship with local SSA field office staff, by securing a representative for homeless disability claimants, and by assuring that consultative examinations are conducted by physicians with significant experience in treating homeless patients.
5. Assist homeless people who are inappropriately denied coverage with timely appeals.
6. Routinely document the insurance status of clients who are likely to qualify for Medicaid, including persons with disabling mental and medical conditions, homeless families, and emancipated or unaccompanied minors. Efforts should be made to identify and address barriers to enrollment.
7. Evaluate efforts to get eligible homeless clients enrolled in Medicaid, based on data they are able to collect.

What State and County Medicaid agencies can do

All state and county Medicaid offices can

1. Assure that all eligibility workers understand current Medicaid policy and procedures; promote outreach efforts to enroll eligible applicants and keep them enrolled.
2. Insist upon more sensitive treatment of Medicaid applicants by eligibility workers and faster response to their inquiries; hire more eligibility workers with smaller caseloads.
3. Provide written information that is comprehensible to applicants explaining Medicaid eligibility, application, enrollment, and beneficiary rights. Provide language-appropriate forms and assistance for applicants.
4. Simplify the application form and procedures for Medicaid applicants.
5. Establish less rigid documentation requirements, similar to those used for the SCHIP program; require only documentation specified in the federal Medicaid statute for certification and recertification.
6. Outstation eligibility workers in more Federally Qualified Health Centers where homeless people receive services.

7. Implement state options under federal policy to eliminate assets requirements for Medicaid eligibility.
8. Discontinue personal interview requirements for eligibility determination and redetermination; permit mail-in Medicaid applications and documentation required to verify eligibility.
9. Properly implement presumptive eligibility for homeless pregnant women and children. Expand eligibility to include family members of children on Medicaid.
10. Actively engage in community-based working groups to identify and address Medicaid enrollment barriers for homeless people. Such groups should include homeless consumers and their advocates, and representatives of all agencies involved in the application and enrollment process.
11. Add a data field to Medicaid information management systems indicating housing status so that homeless beneficiaries can be targeted for special outreach during reverification periods.
12. Require recertification no more than once annually or when circumstances affecting eligibility change.
13. Require only new information during reverification of eligibility. Retrieve existing information from state databases rather than asking recipients to provide the same documentation again.
14. Provide timely information on the disposition of cases (e.g., applications approved and denied, cases recertified or terminated) to parties authorized to provide covered services.
15. Protect Medicaid beneficiaries' due process rights under federal law when there is reason to suspect that they no longer meet criteria for one category of eligibility — i.e., the right to *ex parte* determination, to timely notification of termination or changes in eligibility requirements, to appeal decisions affecting eligibility, and to continued coverage of benefits while *ex parte* determinations and appeals are pending.
16. Improve administrative coordination and simplicity by consolidating Medicaid eligibility determination in one agency that is responsible for oversight of application, follow-up and reverification.
17. Establish Homeless Eligibility Units to do outreach, train eligibility workers, and reduce enrollment barriers for homeless applicants.

What State legislatures can do

State legislatures can

1. Consolidate responsibility for determination of eligibility for all categories of Medicaid coverage within one state agency. Give that agency sufficient authority and resources to create automated eligibility determination systems that meet federal standards.
2. Implement state options under the federal Medicaid statute to expand eligibility to more low-income persons who lack health insurance, including the parents of children on Medicaid and single adults without dependent children.
3. Implement state options under federal policy to eliminate assets requirements for Medicaid eligibility.
4. Establish presumptive eligibility for Medicaid applicants whose eligibility is not determined within legal time limits.
5. Mandate access to affordable, quality health care for all state residents.

What HCFA can do

The Health Care Financing Administration can

1. Set national standards for automated eligibility determination systems used by State Medicaid agencies.
2. Monitor state adherence to federal Medicaid law and regulations—particularly beneficiaries' due process rights, including rights to *ex parte* reviews upon redetermination of eligibility.
3. Promote the provision of language-appropriate Medicaid information, application forms and assistance for Medicaid applicants.
4. Work closely with the SSA and SAMHSA to address current barriers to timely and accurate determination of SSI-related Medicaid eligibility for homeless claimants.
5. Work closely with HRSA to identify barriers to Medicaid enrollment for special populations including homeless people, and recommend solutions.

What HRSA can do

The Health Resources and Service Administration can

1. Provide additional resources to HCH grantees for intensive case management and entitlement assistance to homeless clients.
2. Work closely with HCFA to educate HCH grantees and service recipients about current Medicaid policy.
3. Collaborate with the SSA and SAMHSA to assure that disability claims from homeless people are not disproportionately denied.
4. Provide technical assistance in the design and provision of information systems to enable HCH projects to track the insurance status of clients who are likely to be eligible for Medicaid.

What SAMHSA can do

The Substance Abuse and Mental Health Services Administration can

1. Educate policy makers about the need for expansion of Medicaid coverage to include all homeless persons with alcohol and drug problems;
2. Work closely with other DHHS agencies and the SSA to assure that federal and state regulations do not prevent homeless persons with severe mental illness (with or without co-occurring substance abuse problems) from obtaining Medicaid coverage.

What SSA can do

The Social Security Administration and local field offices can

1. Create Homeless Claims Units or Homeless Claims Specialists in each state's Disability Determination Service, as has been done in Massachusetts, and ensure that the DDS conduct its own outreach to homeless service providers.
2. Work with homeless advocates to resolve disproportionately high denial rates for homeless disability claims. Explore barriers to obtaining consultative examinations.
3. Streamline SSI-related Medicaid eligibility determination systems and shorten the eligibility determination process.

4. Encourage District Offices to engage in both outreach and application assistance at emergency shelters and other sites where homeless individuals are found.
5. Ensure that claims representatives are sensitive to homeless individuals and knowledgeable about procedures involved in processing their disability claims.
6. Encourage the District Offices to flag homeless claims before sending them to the DDS to assure that cases are routed to disability examiners who are familiar with processing this type of claim.

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APPENDIX A

Medicaid Survey Respondents

33/89 = 37% return

Birmingham HCH - Birmingham, AL
Maricopa County Dept Public Health HCH - Phoenix, AZ
Contra Costa Health Svcs HCH - Martinez, CA
San Diego Health Care for the Homeless - San Diego, CA
Venice Family Clinic – Venice, CA
Charter Oak Terrace/Rice Heights Health Center, Inc. - Hartford, CT
Camillus Health Concern, Inc.- Miami, FL
The Outreach Project, Broadlawns Medical Center - Des Moines, IA
Terry-Reilly Health Services - Boise, ID
Chicago Health Outreach, Chicago, IL
Family Health Centers, Inc., HCH Project - Louisville, KY
Boston Health Care for the Homeless Program - Boston, MA
HCH Mercy Hospital - Springfield, MA
Health Care for the Homeless, Inc. - Baltimore, MD
St. Mary's Heartside Clinic - Grand Rapids, MI
Nursing Clinic of Battle Creek - Battle Creek, MI
Grace Hill Neighborhood Health Centers, Inc. - St. Louis, MO
Swope Parkway Health Ctr's HCH - Kansas City, MO
West Side Community Health Services – St. Paul, MN
Yellowstone City-County Health Dept. HCH - Billings, MT
Mobile Community Health Team Project/CHC Community Svcs - Manchester, NH
Albuquerque Health Care for the Homeless - Albuquerque, NM
Care for the Homeless - New York, NY
New York Children's Health Project – New York, NY
Care Alliance – Cleveland, OH
Healing Hands Health Care – Oklahoma City, OK
White Bird Homeless Health Care clinic - Eugene, OR
Health Care for the Homeless/PCHS, Inc., Alma Illery Medical Center - Pittsburgh, PA
Homeless Health Care Center - Chattanooga, TN
Community Health Center of Lubbock - Lubbock, TX
Wasatch Homeless Health Care, Inc. - Salt Lake City, UT
HCH Milwaukee, Inc. - Milwaukee, WI
Cheyenne Crossroads Clinic, Community Action Laramie County - Cheyenne, WY

APPENDIX B

Barriers to Medicaid Enrollment for Eligible Homeless Persons: A Survey of Federal HCH grantees, November–December, 2000

The National Health Care for the Homeless Council is investigating the gap between Medicaid eligibility and Medicaid enrollment in the homeless population. We need your input about barriers your homeless clients face and ideas about solutions.

Please ask a person from your agency with experience in Medicaid application or enrollment (e.g., case manager) to complete the following survey with input from your entire social services team, and return it to **Pat Post** at ppost@nhchc.org or **615/226-1656** (fax).

Project name _____

Person completing this survey _____

phone number _____ e-mail address _____

1. Please estimate how many and what percent of your agency's homeless clients during the past 12 months were probably eligible for Medicaid but NOT enrolled:
_____ number _____ %
2. Listed below are reasons why persons eligible for Medicaid may not be enrolled. On a scale of 1 to 5, please rate how serious a problem each enrollment obstacle is for your clients:

5 = *very serious* – prevents large numbers of our clients from enrolling each year

4 = *serious* – significant problem for clients on a regular basis

3 = *moderately serious* – frequently encountered by a few clients

2 = *minor problem* – occasionally encountered but fairly easily resolved

1 = *not a problem* – rarely or never encountered by our clients

0 = *not applicable to our organization*

Failure to apply:

___ for extended Medicaid beyond period of presumptive eligibility (e.g., pregnant women)

___ diverted into work-first program, bypassing application for Medicaid

___ legal immigrant or naturalized citizen discouraged from applying

___ undocumented person – did not apply for self or child(ren) for fear of being reported to INS

___ did not apply because thought they weren't eligible

___ refused/reluctant to apply

___ impaired capacity to apply (e.g., mental illness)

___ lack of access to enrollment site or person

___ unable to mail in Medicaid application

___ for spend-down Medicaid – unaware of eligibility/ discouraged from applying

___ other reason(s) _____

Applied but never enrolled:

- problem meeting verification requirements (e.g., birth certificate, documentation of resources)
- application terminated when contact information missing or mail undeliverable
- administrative error by eligibility determination agency
- client failure to follow up
- portability problem - qualified for Medicaid in one state, moved to another
- problem obtaining documentation of mental disability to qualify for SSI
- problem obtaining documentation of other disability to qualify for SSI
- application terminated for failure to complete a TANF requirement
- child eligible for Medicaid enrolled in CHIP program not linked to Medicaid
- other reason(s) _____

Coverage denied:

- for lack of required documentation (e.g., birth certificate, proof of resources)
- when TANF application denied or not offered
- for emergency Medicaid/public health services
- for asymptomatic HIV/AIDS under SSI-Medicaid
- for temporary disability (persisting less than period required for SSI eligibility)
- other reason(s) _____

Disenrolled:

- loss of Medicaid for self or child(ren) when rolled off TANF
- for violating TANF requirements
- problems with medical/child support
- as sanction for outstanding fines or warrants
- for failure to respond to reverification notice (not received)
- for failure to present required documentation at reverification
- other reason(s) _____

Please list any other reasons why homeless people you serve are likely to be eligible for Medicaid but not enrolled:

- 1.
- 2.
- 3.

Can your project track and report on cases in which some or all of the barriers listed above prevented enrollment in Medicaid? Yes No

If so, would your project be willing to report how many clients encountered these barriers for a period of time? Yes No

3. What is your project doing to facilitate Medicaid enrollment for homeless people?

- a. Are Medicaid eligibility workers outstationed at your HCH project? Yes No
- b. Is someone on your staff trained and authorized to determine Medicaid eligibility? Yes No
- c. Does your project determine presumptive Medicaid eligibility for pregnant women or children? Yes No
- d. Does your project provide Medicaid benefits counseling, referral or application assistance to homeless people?
 Yes No
- e. Other: _____

4. What would help your project get more homeless people on Medicaid?

Thank you for completing this survey. Your responses will help us to identify the Medicaid enrollment barriers that homeless people face, and what can be done to overcome them. Please fax or e-mail the completed survey to **Pat Post (615/226-1656, ppost@nhchc.org)** as soon as possible. *[Survey e-mailed to 89 grantees in November 2000. Re-sent to projects that did not respond in December.]*

APPENDIX C

Summary of Survey Responses

1. Estimated number/percentage of homeless clients served during the last year who were probably eligible for Medicaid but not enrolled

**Table 1. Probably eligible for Medicaid but not enrolled:
Number of homeless clients, last 12 mos**

Number of clients	% of respondents
< 200	23%
200–400	32%
400–900	18%
> 900	27%
Total: 16,831	n=22

mean=765 standard deviation=879 median=315 mode=250 range: 45–3600

Estimates by the 22 HCH projects that responded to this question varied considerably. Over half (55%) estimated that fewer than 400 homeless clients served during the last 12 months should have been on Medicaid but were not. Nearly one-fourth (23%) of respondents reported that 200 or fewer homeless clients should have qualified for Medicaid last year but did not; and about one-fourth (27%) estimated that over 900 such clients probably met Medicaid eligibility criteria but were not enrolled. The median number of clients thought to be eligible for Medicaid but not enrolled was 315, within a broad range of 45–3600. Approximately 17,000 uninsured homeless clients in all were estimated to be probably eligible for Medicaid but not enrolled during the last year.

**Table 2. Probably eligible for Medicaid but Not Enrolled:
Percentage of homeless clients, last 12 mos**

% of clients	% of respondents
<10%	35%
10%–30%	48%
30%–50%	10%
> 50%	6%
total: 100%	n=31

mean=18% standard deviation=16% median=10% mode=10% range: 2%–60%

Over 80% of 31 respondents to this question estimated that less than one-third of the clients they served last year probably met Medicaid eligibility criteria but were uninsured. Nearly half (48%) of respondents estimated that between 10% and 30% of their clients should have qualified for Medicaid. Over one-third (35%) estimated that less than 10% of their homeless clients last year were eligible but not enrolled. One-sixth (16%) thought more than 30% of their clients should have qualified for Medicaid. Only two projects (6%) reported that more than 50% of their clients without Medicaid coverage last year were probably eligible. The median response was 10%, ranging from 2% to 60%.

2. Comparative seriousness of Medicaid enrollment barriers for homeless people as perceived by HCH providers

All 30 potential enrollment barriers evaluated were rated as problematic to some degree by at least 44% of respondents.

1. Missing contact information on the Medicaid application resulting in undeliverable mail was rated “very serious” by the highest percentage of respondents.
 - Client failure to follow up was most often identified as a “serious” problem by the highest percentage of respondents.
 - Refusal or reluctance to apply was most frequently rated as “moderately serious.”
 - Problems with medical or child support, failure to apply for extended coverage beyond the presumptive eligibility period, and administrative error by the eligibility determination agency were selected by the highest percentages of respondents as “minor problems.”

99%–100% of respondents reported that homeless clients considered likely to qualify for Medicaid

- Failed to apply because clients **thought they weren’t eligible.**
- Applied but never enrolled because of **missing contact information/** failure to receive mailed notices, or **problem meeting verification requirements** (data/place of birth, proof of income or employment, documentation of disability, etc.), or **failure to follow up after applying.**
- Were denied Medicaid for **lack of required documentation.**
- Were disenrolled after qualifying because **did not respond to the reverification** notice or responded but **failed to present required documentation** for reverification.

Over 50% of respondents reported that homeless clients considered likely to qualify for Medicaid

- Failed to apply because of **impaired capacity** or because **they didn’t think they were eligible;**
- Applied but never enrolled because **contact information on the application was missing** and mail was undeliverable, or because of **failure to follow up after applying,** or because of a **problem meeting verification requirements** (e.g., income/assets, age).
- Were disenrolled because of **failure to receive/respond to reverification notice** or **failure to present documentation required for reverification.**

All enrollment obstacles listed in Tables 3–6 were given a score of 2–5. Obstacles are ranked according to their perceived seriousness within each explanatory category. The rank of each potential obstacle was determined by the percentage of respondents identifying it as problematic for their clients. That is, they are ranked according to the total percentage of respondents who rated them as “2–minor,” “3–moderately serious,” “4–serious,” or “5–very serious” problems.

**Table 3. Why eligible homeless clients are not on Medicaid:
FAILURE TO APPLY**

Enrollment Obstacles	Level of Seriousness				
	5	4	3	2	Total %
1. clients thought they weren't eligible	32%	21%	26%	21%	100%
2. impaired capacity to apply	32%	24%	21%	21%	98%
3. refused/reluctant to apply	24%	9%	33%	30%	96%
4. fear of being reported to INS	23%	19%	16%	29%	87%
5. for extended coverage beyond presumptive eligibility	6%	9%	27%	33%	75%
6. lack of access to enrollment site or person	9%	24%	18%	21%	72%
7. unaware of/discouraged from applying for spend-down Medicaid	13%	10%	29%	19%	71%
8. unable to mail in Medicaid application	6%	15%	18%	27%	66%
9. legal immigrant or naturalized citizen discouraged from applying	16%	0%	19%	25%	60%
10. diverted into work-first program bypassing Medicaid application	3%	13%	16%	19%	51%

**Table 4. Why eligible homeless clients are not on Medicaid:
APPLIED BUT NEVER ENROLLED**

Enrollment Obstacles	Levels of Seriousness				
	5	4	3	2	Total
1. contact information missing/mail undeliverable	53%	26%	18%	3%	100%
2. problem meeting verification requirements	35%	29%	24%	12%	100%
3. client failure to follow up	29%	50%	21%	0%	100%
4. problem obtaining documentation of physical disability	21%	21%	29%	18%	89%
5. problem obtaining documentation of mental disability	24%	21%	27%	15%	87%
6. qualified in one state, moved to another	24%	12%	21%	30%	87%
7. failure to complete TANF requirement	9%	22%	28%	22%	81%
8. administrative error by eligibility determination agency	3%	15%	24%	33%	75%
9. eligible child enrolled in CHIP program not linked to Medicaid	0%	17%	7%	21%	45%

**Table 5. Why eligible homeless clients are not on Medicaid:
APPLICATION DENIED**

Enrollment Obstacles	Level of Seriousness				
	5	4	3	2	total %
1. lack of required documentation	36%	27%	21%	15%	99%
2. temporary disability insufficient to qualify for SSI–Medicaid	20%	20%	20%	20%	80%
3. for emergency Medicaid or public health services	10%	17%	24%	24%	75%
4. asymptomatic HIV/AIDS, not meeting SSI criteria	17%	3%	17%	27%	64%
5. when TANF application denied or not offered	3%	33%	10%	7%	53%

**Table 6. Why eligible homeless clients are not on Medicaid:
DISENROLLED**

Enrollment Obstacles	Level of Seriousness				
	5	4	3	2	total %
1. failure to respond to reverification notice (not received)	41%	41%	12%	6%	100%
2. failure to present required documentation at reverification	35%	26%	19%	19%	99%
3. loss of Medicaid for self/child when rolled off TANF	28%	21%	17%	14%	80%
4. for violating TANF requirements	15%	19%	19%	19%	72%
5. problems with medical/child support	3%	10%	17%	34%	64%
6. as sanction for outstanding fines or warrants	0%	13%	10%	23%	46%

When asked to identify other enrollment obstacles not specified in the survey, respondents tended to address ultimate reasons why eligible homeless people do not enroll or remain enrolled in Medicaid—that is, reasons that explain the enrollment barriers specified in survey questions. They pointed to two sorts of problems that deter enrollment for homeless people: system inadequacies and problems associated with homelessness.

**Table 7. Why eligible homeless clients are not on Medicaid:
OTHER ENROLLMENT BARRIERS:**

System Inadequacies	Level of Seriousness, if specified				
	5	4	3	2	total
Complicated application system			1		3
Lack of on-site eligibility determination (at homeless service sites)	1				2
Erroneous or incomplete information about who is eligible	1				2
Poorly trained eligibility workers, high turnover rate					2
Inaccessible providers of covered services under managed care					2
Lengthy eligibility decision making process	1				1
Application form doesn't elicit needed information from providers	1				1
Lack of interpreters or bilingual intake workers at Medicaid office		1			1
Dehumanizing attitude of eligibility workers					1
Lack of entitlement assistance from shelter staff					1
Insufficient number of agencies assisting with SSI applications					1
Lack of reasonable accommodation for severely disabled clients					1
Lack of availability of physicians authorized to determine medical disability					1
Lack of state outreach efforts to enroll homeless persons					1
Insufficient case management					1

**Table 8. Why eligible homeless clients are not on Medicaid:
OTHER ENROLLMENT BARRIERS**

Problems Intrinsic to Homelessness	Level of Seriousness, if specified				
	5	4	3	2	total
Lack of verifiable documentation: proof of residence, income (out-of-state ID, lack of in-state address)			1		9
Mental illness (sometimes undiagnosed), substance use/abuse					5
Lack of transportation to get required documentation/complete enrollment		1			3
Transience (e.g., runaway teens)			1		3
Educational and functional limitations (e.g., illiteracy)					3
Reluctance to apply for fear of losing child (being reported to CPS)	1				1
Lack of resources to renew application (obtain required documentation)		1			1
Fear of law enforcement efforts to drive homeless from the area			1		1
Premiums unpaid from previous eligibility period			1		1
Unable to afford co-payments for covered services					1
Intimidated by paperwork					1
Mistrustful of government programs from past experience					1
Unaware of useful resources/services available through Medicaid					1
Enrolled but unaware they were approved					1

3. How HCH projects are facilitating Medicaid enrollment for homeless people

The survey explicitly asked homeless service providers whether or not they are providing the following services to facilitate Medicaid enrollment:

- Outstationed eligibility workers.** Availability of Medicaid eligibility workers at sites where homeless services are provided was repeatedly cited as an important means of facilitating enrollment. As noted, state Medicaid agencies are required to provide on-site eligibility determination at all Federally Qualified Health Centers (FQHCs) serving pregnant women and children. But only 41% of respondents reported that on-site eligibility workers were available at their projects— in Arizona, California, Florida, Illinois, Minnesota, Missouri, New Mexico, Pennsylvania, Texas and Utah. (In Iowa, as in some other states, the HCH project is affiliated with a Community Health Center that has an eligibility worker.)
- Staff member trained and authorized to determine Medicaid eligibility.** Of HCH projects responding to this survey, 39%—in California (3 sites), Connecticut, Illinois, Michigan, Missouri, Montana, New Mexico, New York and Wisconsin—reported that someone on their staff is authorized to determine Medicaid eligibility. (*On follow-up, we learned that these reported individuals were either outstationed eligibility workers from the State Medicaid or welfare agency who worked on-site in HCH projects, or HCH employees who provided application assistance only, but did not actually determine eligibility. HCFA confirms that only employees of the single State Medicaid agency or welfare agency may actually determine Medicaid eligibility, although other trained individuals may assist with the application process and even make recommendations regarding eligibility status.*)

- **On-site presumptive eligibility determination for pregnant women and/or children.** Less than half of respondents (48%) said that HCH project staff determine presumptive Medicaid eligibility—in California (3 sites), Connecticut, Illinois, Missouri, Montana, New Mexico, Oklahoma, Oregon, Pennsylvania, Texas, Utah, Wisconsin and Wyoming.
- **Medicaid benefits counseling, referral or application assistance.** Nearly all respondents (94%) said they provide these services to homeless clients. Application assistance includes client education about entitlements, provision of applications, and assistance filling them out.

In addition to the types of assistance listed above, federal HCH grantees reported a number of other services they provide to reduce Medicaid enrollment barriers. These include:

- **Case management** and education of homeless clients about HMO assignment;
- **Staff training** in entitlement assistance at community-based organizations;
- **Identification of clients likely to be eligible**, application assistance and follow-up;
- **Provision of medical evaluations** and assistance with disability determination;
- **Entitlement outreach to homeless people** in area shelters and soup kitchens;
- **Individual advocacy** to help homeless clients negotiate Medicaid managed care systems;
- **Policy advocacy** to expand Medicaid eligibility for single adults with disabilities.

4. How to get more homeless people on Medicaid

Finally, surveyed federal HCH grantees were asked to specify what would help them get more homeless people on Medicaid. Following is a summary of their responses:

Implementation and enforcement of current policy:

- Outstationed eligibility workers and benefits counselors in more homeless service sites;
- Presumptive eligibility for homeless children in all states;
- Expansion of coverage to parents of Medicaid eligible children.

Policy changes:

- Expansion of Medicaid eligibility to include all homeless persons;
- Less rigid time and documentation requirements for verification and reverification of eligibility.

Systems changes – improved application/certification process:

- SSI-Medicaid eligibility determination systems changes;
- Shorter eligibility determination process;
- Dedicated Medicaid office for application, follow-up and reverification;
- More eligibility workers, smaller case loads;
- Improved administrative coordination and simplicity;
- Transportation assistance for homeless applicants required to have face-to-face interviews;
- Authorization of outreach workers to assist clients with application process;
- HCH project access to patient data (Social Security numbers) in Medicaid database;
- Handouts in comprehensible language explaining Medicaid eligibility.

Improved treatment of homeless applicants:

- More positive attitude of government workers toward persons seeking entitlements;
- Faster, more sensitive response to applicant inquiries.

Funding assistance:

- to support intensive case management;
- to obtain required documentation (e.g., birth certificates);
- to enable more application assistance by project staff;
- to increase capacity for administrative advocacy to speed Medicaid expansions.

Improved education about Medicaid requirements and procedures:

- for entitlement workers;
- for application assistance staff;
- for homeless people.

APPENDIX D

Additional Information from Eight HCH Projects in Seven States

KENTUCKY

Family Health Centers, Inc., HCH Project, Louisville-Jefferson County, Kentucky:

Family Health Centers in Louisville, Kentucky, tracked homeless patients seen by physicians or nurse practitioners in the HCH funded Phoenix Health Center and in HCH funded shelter health rooms during the year 2000. Of 4,078 homeless persons receiving health services at the HCH project in 2000, 95% had no health insurance. Of the 5% who had health insurance, 3.6% had managed care Medicaid (Passport), 0.4% had non-managed care Medicaid, 0.9% had Medicare, and 0.1% had private insurance.

Passport serves only Louisville and surrounding counties. According to this respondent, it is the only successfully established Medicaid managed care program in Kentucky. In contrast to managed care systems in other states, Passport has benefited patients and community health centers, he says. Nevertheless, it has not been terribly beneficial to the HCH Project, which receives a small fee for services provided to homeless persons already on Passport but assigned to another health care provider. The HCH Project does not serve as a primary care provider for Passport patients.

To receive Medicaid in Kentucky, persons in poverty who are not in families must be determined disabled according to Social Security Administration criteria. The HCH Project serves very few persons (0.4%) not in families who have fee-for-service (non-managed care) Medicaid. Nevertheless, the vast majority of service recipients are single adults. Four percent (n= 113) of the all adults not in families have either Medicaid or Passport due to disabling physical or mental illnesses as determined by the Social Security Administration.

All patients: Table F shows the number of homeless clients who received health services in year 2000 from physicians or nurse practitioners at HCH funded sites in Louisville. Of the 3,473 patients served, 95% were uninsured and of the 5% that had insurance, 4% were on Passport (Medicaid managed care) and .4% on Medicaid fee-for-service.

Table F: Insurance status of all homeless patients seen by MDs or NPs at HCH Project sites in Louisville, KY, 2000

Category	Number	Percent
Patients with no insurance	3,293	94.8%
Patients with insurance	180	5.2%
• Medicaid (non-managed care)	13*	0.4%
• Passport (Medicaid managed care)	126	3.6%
• Medicare	31*	0.9%
• Private	10	0.3%
Total Patients served	3,473	100%

*Some patients had both Medicaid and Medicare.

Children: Table G shows the insurance status of children seen by HCH providers in 2000. Of the 341 homeless children (ages 17 and under) served, 88% were reported to have no health insurance and 12% had Passport (Medicaid managed care) obtained through TANF eligibility.

Table G: Insurance status of homeless children seen by MDs or NPs at HCH Project sites in Louisville, KY, 2000

Category	Number	Percent	Notes
Children with no insurance	341	88.1%	% of all children served
Children with insurance	46	11.9%	% of all children served
• Passport	46	100%	% of children with insurance
Total Children Served	341	100%	11.1% of all patients served

Adults with Children: Table H shows the insurance status of adults in families (with children) seen by HCH providers in 2000. Of the 226 homeless adults with children served, 91% were uninsured and 9.0% had health insurance all through Passport (Medicaid managed care).

Table H: Insurance status of Adults in Families seen by MDs or NPs at HCH Project sites in Louisville, KY, 2000

Category	Number	Percent	Notes
Adults with no insurance	207	91.0%	% of all adults with children
Adults with insurance	19	9.0%	% of all adults with children
• Passport	19	.95%	% of insured adults in families
• Private Insurance	1	0.5%	% of insured adults in families
Total Adults in Families	226	100%	7.2% of all patients served

These homeless clients may lack health insurance for a variety of reasons:

- The family has arrived from out of state;
- They are eligible for but not receiving TANF;
- An adult family member has recently lost a job and is in the process of applying for another;
- They are working and not eligible for TANF.

Other patients reported as uninsured may actually have health coverage, but not be so recorded in the HCH Project database because:

- They lost their Passport card or other information;
- Staff failed to ask or record persons that have Passport; or
- Patients said they don't have Passport when they do. (Some may not know it.)

Four percent (n= 113) of the all adults not in families have Medicaid or Passport due to disabling physical or mental illnesses as determined by the Social Security Administration.

“Given that 88% of children served last year were recorded as having no insurance but are apparently eligible for Passport, there needs to be a greater effort on the part of the HCH Project to discover why potentially eligible children are not receiving Medicaid benefits,” concludes executive director, Bart Irwin.

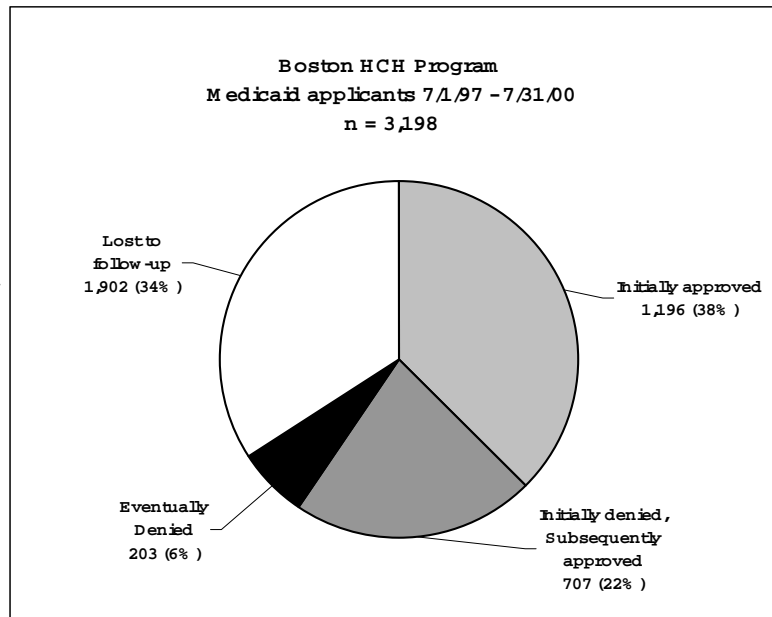
MASSACHUSETTS

Boston Health Care for the Homeless Program (BHCHP)

APPLICATION Boston Health Care for the Homeless Program tracked 3,198 homeless Medicaid applicants (about 23% of all clients) seen by their agency between 7/1/97 and 7/31/2000. They found that 1,903 (60%) of these applicants were eventually approved for Medicaid, that 203 (6%) were eventually denied, and that 1,092 (34%) were lost to follow-up. Thus eligibility was undetermined for over one-third of applicants.

Loss to follow-up occurred either because BHCHP did not receive a copy of Medicaid's response to the client's application, or because data entry at BHCHP was incomplete. Unless there are convincing reasons why homeless applicants lost to follow-up were more likely than others to be ineligible for Medicaid, it is not unreasonable to assume that as many as 655

more applicants (60% of those lost to follow-up) might well have enrolled. Thus *it is possible to infer from these data that with aggressive interagency follow-up and advocacy, at least 80% of homeless applicants might have qualified for health coverage during this three-year period, instead of the 60% of applicants known to have qualified.*



Of 1,903 Medicaid applications eventually approved, 1,196 (63%) were initially approved and 707 (37%) were initially rejected or deferred, requiring follow-up and advocacy to obtain ultimate approval. Over three-fourths of the 910 initial Medicaid denials (707) were subsequently approved when clients whose mail had been returned were located, when missing information on the application form was completed, or when a processing error was identified and corrected.

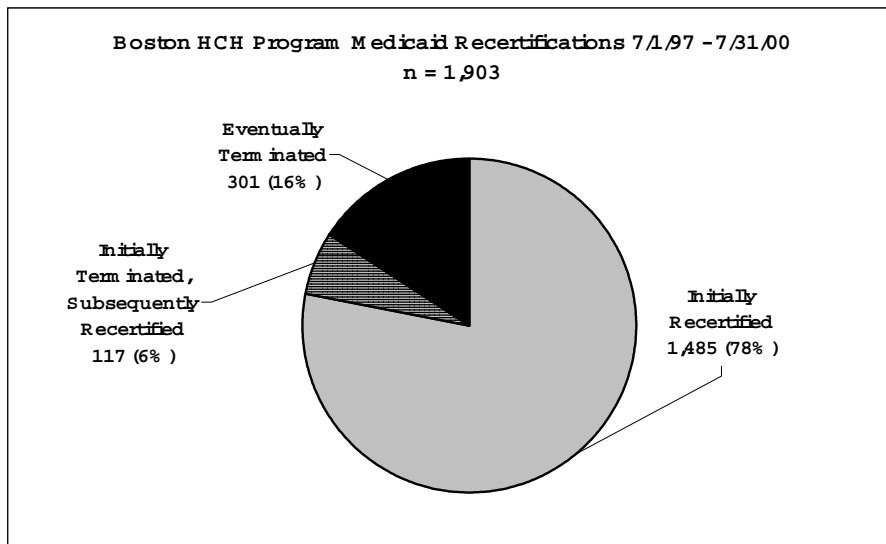
The 203 clients whose applications were eventually denied fell into one of three categories:

1. Undocumented,
2. Did not meet expanded state eligibility criteria because they had been employed within the last 12 months, or
3. Did not meet standard eligibility criteria because they were not found to be disabled.

RECERTIFICATION Boston HCH also examined the extent to which clients who qualified for Medicaid were able to remain on the program following the annual eligibility review. Of 1,903 homeless clients who were enrolled in Medicaid between July 1997 and August 2000, 418 clients (28%) were terminated following an eligibility review. Terminations occurred because of failure to return the Eligibility Review Form, because a client's whereabouts were unknown, or because the client no longer met eligibility criteria. Of the 418 homeless clients who were terminated for one of these

reasons, 117 (28% of redeterminations) were reinstated on follow-up and 301 (62% of redeterminations) were not reinstated. (Most of these individuals were lost to follow-up.)

Thus with aggressive follow-up, and the willingness of the State Medicaid program to address the problems that were identified by aggressive tracking 824 more homeless clients were able to obtain or retain Medicaid coverage than would have qualified without these efforts. These individuals represented 20% of clients lacking health insurance who were seen between, July 1997 and July 2000.



It is evident from these data that despite the best intentions of a state that advocates describe as being highly committed to enrolling homeless people in Medicaid and serving them well, significant numbers of eligible persons do not qualify for coverage without aggressive follow-up and advocacy by homeless service providers. Despite efforts to avoid terminating applications when mail is undeliverable or if contact information on the application is missing, homeless people still fall through the cracks. Even when applications are approved, homeless people often lose Medicaid eligibility when recertification forms are mailed but never received, or required documentation is not available.

“The Massachusetts Medicaid Administration has been exceptionally committed to making sure that Medicaid services work for people who are homeless, but even systems and logistics that are designed for persons who are homeless require intense monitoring and advocacy,” observes BHCHP executive director Robert Taube. “All such systems succeed or fail based on the accuracy and completeness of information identifying housing status or homelessness.”

DISABILITY CLAIMS Homeless health care providers in several states report that most SSI -Medicaid applications are initially denied. Allowance rates for initial SSI applications vary widely from state to state. In Oklahoma, the denial rate is reported to be as high as 95%.⁹ Although Massachusetts allows more disability claims for homeless individuals than most other states, denials are over twice as many as allowances (2.4 times as great for homeless claimants versus 1.6 times as great for all claimants). Of 1,246 disability claims filed by homeless persons in Boston, 9/1/98–5/31/99, 358 (29%) were allowed, 878 (70%) denied, and 10 (1%) had no determination or were in transition.¹⁰ This allowance rate for homeless claimants is lower than the state’s average initial allowance rate of about 39%.¹¹

⁹ cf. Susan Geurin, program coordinator, Healing Hands Health Services, Oklahoma City.

¹⁰ Memo from Homeless Subcommittee to Massachusetts Department of Disability Services (DDS) Advisory Committee re: concerns regarding homeless [disability] claims, April 26, 2000.

¹¹ 1/29/01 conversation with Sarah Anderson, Senior Attorney, Greater Boston Legal Services; advocate member, Homeless Subcommittee of the DDS Advisory Committee; member, Boston HCH Program’s Board of Directors.

Barriers Encountered by Homeless Disability Claimants in Boston, Massachusetts:

In Massachusetts, disabled persons can qualify for federal disability and/or Medicaid without applying for SSI. Nevertheless, the following data on SSI claims are illustrative of reasons why homeless persons are kept off Medicaid in the 38 states where it is linked to SSI eligibility.^{1,29}

The Massachusetts Department of Disability Services' (DDS) Advisory Committee appointed a Homeless Subcommittee to investigate barriers that homeless claimants face in applying for SSDI/SSI disability benefits under Title II and Title XVI of the Social Security Act. The Homeless Subcommittee's appointed members include DDS homeless disability claims specialists, consumers and advocates. In an April 2000 memo to the Massachusetts DDS Advisory Committee, the workgroup identified the following impediments to homeless disability claimants:

2. Disability determination is delayed when claimants do not list addresses and telephone numbers of all medical providers;
3. In some cases, SSA intake workers are insensitive to difficulties faced by homeless people, including mental illness and dual diagnosis;
4. Decisions usually take 90 days, but many homeless individuals leave emergency shelters within 30 days, failing to notify DDS of their new address;
5. Homeless claimants frequently fail to identify a third party contact who could be helpful to the processing of their claim;
6. In many cases, the local SSA field office doesn't flag homeless cases with a cover sheet for the DDS Homeless Unit.

Reasons given by the SSA field office for the denial of SSI and SSDI disability claims are summarized in Tables A and B. (SSDI is linked to Medicare coverage, and SSI is linked to Medicaid coverage in most states.)

**Table A. Reasons for 218 denials of homeless SSDI claims, 9/1/98–5/31/99
Department of Disability Services, Boston, Massachusetts**

Percentage	Reason for Denial
25%	Can do other work; condition severe but does not meet requirements
22%	Insufficient medical evidence
15%	Failure to keep consultative examination appointment
11%	Drug/alcohol use is material to the decision
8%	Condition will not last 12 months

**Table B. Reasons for 407 denials of homeless SSI claims, 9/1/98–5/31/99
Department of Disability Services, Boston, Massachusetts**

Percentage	Reason for Denial
28%	Can do other work; condition severe but does not meet requirements
20%	Failure to keep consultative examination appointment
14%	Failure to follow prescribed substance abuse treatment
13%	Insufficient medical evidence
10%	Lacking severity
10%	Condition will not last 12 months

Since 25% of HIV disability claimants in Boston are homeless individuals, the total number of homeless SSI claims exceeds those summarized in Table A.

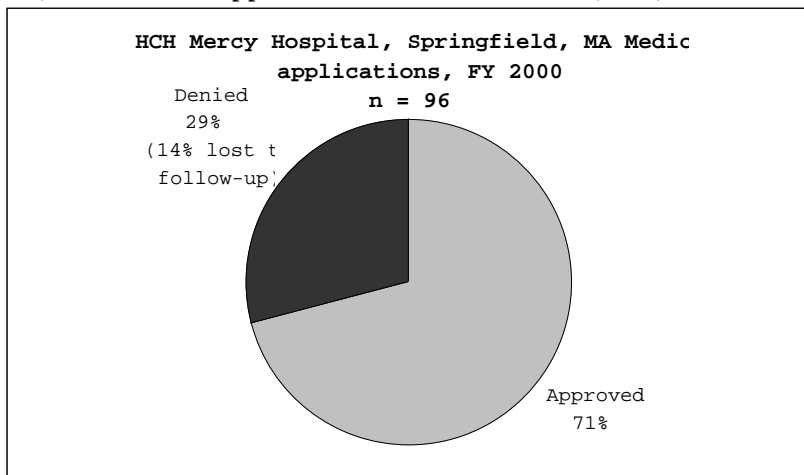
It is interesting to note that at least 37% of SSDI denials and 33% of SSI denials—for failure to keep CE appointments or insufficient medical evidence—might have been reversed with aggressive application assistance and advocacy.

The Homeless Subcommittee of the DDS Advisory Committee has begun to address systems barriers to SSI/SSDI application and enrollment for homeless people in the Boston area through the following remedies:

- Publishing a brochure for claimants and advocates: *An Advocate's Guide: SSI and SSDI Disability Benefits for the Homeless*;
- Maintaining a list of current shelter provider contacts for the DDS Homeless Unit;
- Informing/reminding all DDS employees of the Homeless Unit; revising and distributing *Guidelines for Homeless Claims Case Development* to all DDS staff;
- Requesting that local SSA field offices flag homeless cases for the DDS Homeless Unit and encourage claimants to identify a third party contact;
- Outreach to emergency shelters by local SSA field offices and identification of claimant representatives who are sensitive to homeless individuals; (Boston District office has assigned claimant reps to work 4 hours per month in 4 shelters in the Boston area.)
- Exploring barriers to claimants' attending consultative exams (CEs) and transportation issues;
- Reviewing Program Operations Manual System (POMS), noting procedures and operations that are relevant to homeless claimants;
- Recommending establishment of a Homeless Unit similar to Boston's—i.e., a mechanism for flagging homeless claims and designated staff interested in working with them—in other Massachusetts field offices.

HCH Mercy Hospital, Springfield, Massachusetts

HCH, Springfield tracked approvals and denials of 96 applications for Medicaid filed in Year 2000. Coverage was approved for 68 (71%) of homeless applicants and denied for 28 (29%). Half of those denied were lost to follow-up, precluding discovery of the reasons for denied coverage. Among reasons for denial that could be ascertained was failure to meet the minimum financial or employment standards for eligibility under the state's expanded Medicaid program.



The HCH project reports that it experiences no difficulty getting homeless women or children under age 19 enrolled in Medicaid. Those who remain uninsured are primarily single adults failing to meet at least one of the following sets of requirements for Medicaid coverage through MassHealth, the state's Section 1115 demonstration program:

- **MassHealth coverage for persons meeting citizenship or immigration status requirements:** US citizenship (verified by self-declaration) or meeting state requirements as qualified aliens, protected aliens, or aliens with special status, as defined under 130 CMR, section 504.002; or
 - **State optional Medicaid coverage for unemployed persons:** Failure to work during the past year or income below \$3,000 per year for a single person; or
 - **State optional Medicaid coverage for non-institutionalized disabled persons:** Verified short-term disability expected to last longer than one year for persons living independently with income up to 133% FPL; or
 - **State optional Medically Needy (spend-down Medicaid) program:** Income minus medical expenditures below 78% FPL and resources (assets) under \$2000 for a single person; or
- (Financial requirements specified are 1998 maximums for single individuals, as cited in Bruen, et al, 1999, and on the MassHealth Web site at: www.state.ma.us/dma/masshealthinfo/regulations_eligibility/regs_eligibility_toc.htm)

Qualifying for Medicaid and disability assistance under the federal SSI program is more complicated than under MassHealth, often requiring comprehensive documentation of *all* co-occurring mental and physical problems to demonstrate disability. “Separately, clients’ problems may not qualify them for disability assistance; but they may qualify when the whole picture—all disabling conditions considered together—is taken into consideration,” explains program manager Judith Mealey, NP.

NEW HAMPSHIRE

The Mobile Community Health Team Project at Catholic Medical Center, Manchester, New Hampshire:

The Mobile Community Health Team at Catholic Medical Center is a subcontractor of the homeless health care program at the City of Manchester Public Health Department. In year 2000, 547 homeless clients (72% of all homeless users) had no health insurance. The project conducted a retrospective analysis of 152 of these cases to see how many homeless clients with diagnoses likely to qualify them for Medicaid remained uninsured. *They identified 77 individuals (14% of all uninsured homeless users) who were probably eligible for Medicaid but uninsured*—one undocumented immigrant child, 20 adolescents under age 19, 14 young adults aged 19–24, and 42 adults aged 25–64. These findings are summarized in Table I.

**Table I: Mobile Community Health Team Project, Manchester, NH
Uninsured homeless users probably eligible for Medicaid, FY 2000**

Age in years	Uninsured	Eligible but not enrolled	Medicaid eligibility category
Children 0–16	24	1	Poverty Level Medicaid for children
Adolescents 17-18	27	20	
Youth 19–24	22	14	Disability-based, pregnancy-based or or Spend-down Medicaid
Adults 25–64	79	42	
Totals	152	77*	

*14% of all uninsured homeless users

In New Hampshire, all children under 19 with household income up to 185% FPL are eligible for Medicaid. Runaway or “throwaway” youth seldom apply for Medicaid after leaving their families, state custody or the criminal justice system. These young people and many agencies wrongly assume that they are ineligible for Medicaid because they do not meet APTD disability criteria. Adolescents

aged 17 or 18 who have separated from their families are considered distinct, “one-person” family units. Their poverty level is based on their own income or lack thereof, not upon the income of their parents. This is often a source of confusion to clients and agencies alike.

Adults age 19–64 may qualify for Medicaid only if they are pregnant or disabled. Pregnant women with family income at or below 300% FPL are eligible for Medicaid during pregnancy and for a short time *post partum*. Their infants are covered through the first year of life. To qualify for disability-based Medicaid, an individual must be determined disabled according to state Aid to the Permanently and Totally Disabled (APTD) program criteria, which are more stringent than federal criteria for SSI. Disabling conditions thought likely to qualify homeless adults for state APTD-Medicaid include chronic obstructive pulmonary disease, heart disease, psychiatric disorders and developmental delays.

Homeless persons over 65 qualify for Medicare; some qualify for VA coverage; and the disabled elderly are also dually eligible for Medicaid. Workers who have received disability assistance for 24 months or more are also dually eligible for Medicare and Medicaid. In FY 2000, the Mobile Community Health Team served seven dually insured (Medicare/Medicaid) adults, age 19–64; 11 homeless clients over age 65 had either Medicare or VA coverage.

Seniors are reluctant to apply for Medicaid. They perceive it as “welfare,” according to homeless health care coordinator Marianne Feliciano, BSN, RN. They are averse to revealing their income and assets, and are grateful to have Medicare. Medicare, however, does not provide for the medications that they sorely need. Homeless elderly persons become ineligible for Medicaid as their income rises, ever so slightly, when they receive Social Security pensions. To re-qualify under the Medicaid spend-down program, they must track, tally and deduct medical expenditures from their income each month. They must then have a net income balance within 76% FPL and assets under \$2,500 (for individuals). Clients are reluctant to disclose this information; even if they are willing to do so, they are often unable to obtain required documentation to demonstrate that they have met these financial criteria. Caseworkers report that the spend down process is so cumbersome and confusing that seniors and less experienced case managers think it is “not worth the struggle.”

NEW YORK

Care for the Homeless, New York City:

Care for the Homeless New York City shared results of a Medicaid Enrollment Barriers Study in which they collaborated with the Commission for the Public’s Health System and the greater Upstate Law Project. The New York study describes enrollment barriers experienced by recent Medicaid applicants or observed by professionals providing application assistance in community-based sites including homeless shelters and a community health center serving homeless people. The authors identified 11 enrollment barriers inherent in the application/certification process:

- *Information required on the application form is more than federal law requires.*
- *Verification and documentation requirements are more stringent than federal law requires.*
- *Required Medicaid assets test is not required by federal law and discouraged by HCFA.*
- *Required personal interview is not required by federal law and discouraged by HCFA.*
- *Lack of language-appropriate forms and assistance for applicants fails to meet federal standards.*
- *Finger-imaging requirements are counterproductive and of questionable legality.*

- *Alcohol and drug screening and treatment requirements are not mandated by federal law.*
- *Inconsistent documentation requirements and practices delay or impede application.*
- *Eligibility determination process exceeds federally mandated time limits.*
- *Recertification is required more frequently than federal law and HCFA policy require.*
- *Reapplication requirements for beneficiaries who move from one district to another are contrary to federal law and HCFA policy.*

Virtually all of these barriers are state created rather than federally mandated, resulting from statutory, regulatory and procedural discrepancies between New York’s Medicaid program and the federal Medicaid program, they argue. The authors contend that New York Medicaid law and State Medicaid Agency procedures are often inconsistent with the federal Medicaid statute and state guidance issued by the Health Care Financing Administration (HCFA). The report explains how these enrollment barriers are severely restricting access to health coverage for eligible populations and recommends state legislation to remove them.

MEDICAID ENROLLMENT BARRIERS	Federal Medicaid Law	NY State Medicaid Law	NY State Medicaid Agency Regulations
Number questions on Medicaid application	3	—	20
Number documentation requirements	1	1	20
Asset test for Medicaid eligibility	No	Yes	Yes
Personal interview for new application	No	Yes	Yes
Personal interview for recertification	No	No	Yes*
Alcohol & drug screening requirements	No	Yes	Yes
Eligibility determination time frames	45 days max. for non-disabled	45 days max. for non-disabled	up to 150 days
Recertify every 12 months	Yes	Yes	Yes
Required recertification for beneficiaries with information changes	No	Yes	Yes
Recertification requires unchanged information already submitted with original application	No	Yes	Yes
Requirements to re-apply when applicant moves from local district to local district	No	Yes	Yes

* except Aid to the Blind/Aid to the Disabled

Information about Medicaid enrollment barriers was derived from focus groups and in-depth interviews with recent Medicaid applicants, professionals providing application assistance, and community-based client advocates. The report describes complexities and inconsistencies in the New York Medicaid application process. Factors impeding enrollment are described in detail, including vivid illustrations of frustrations experienced by homeless applicants. Enrollment obstacles on which the report places primary emphasis are:

- **Excessive and repetitive documentation requirements, placing the burden of proof on applicants rather than on worker accountability;**
- **Long, confusing, and redundant application forms;**
- **Mandatory in-person interviews requiring long waiting periods and serial appointments;**
- **Inaccessible Medicaid offices and workers;**
- **Lack of uniformity in the application process and acceptable documentation.**

Environmental barriers:

- Applicants must endure long waiting periods in crowded offices with insufficient staffing.
- Behavior of eligibility workers toward applicants is “dehumanizing.”
- Directions to application offices and assistance with the application process are lacking.
- Language and literacy barriers exacerbate confusing application procedures.
- Worker errors result in confusing, inconsistent procedures and policy interpretations.

In a focus group comprised of mentally ill and chemically addicted (MICA) patients, participants reported that Medicaid workers have a poor attitude about people in substance abuse treatment, are judgmental, and use varied rules for assessing Medicaid applications. Each worker applies the rules differently, and applicants receive no clear enrollment instructions or guidance. In some cases, applicants became discouraged and gave up applying for Medicaid after being treated badly and denied benefits repeatedly.

A Medicaid worker told a homeless man that he needed to have an income to receive Medicaid. He obtained work, making \$40 per week, to meet the supposed income requirement. When he re-applied, the Medicaid worker told him that his income of \$40 per week exceeded the income eligibility level, and he was again turned away and was encouraged to apply for Public Assistance in order to get Medicaid.

Application form barriers:

- The application form is excessively long, confusing and redundant, contributing to applicant errors and application denials.
- A joint form is used to apply for Medicaid, Public Assistance and Food Stamps, requiring unnecessary information to apply for Medicaid only.
- Some questions are perceived as offensive, violating personal privacy.

Participants perceive that they must apply for all benefits—Medicaid, Public Assistance and Food Stamps—even if they wish to apply for Medicaid only. Those who are eligible for Medicaid but not for Public Assistance are invariably rejected for all benefits. Often, those denied eligibility for Public Assistance and Food Stamps are not informed that they can apply for Medicaid.

Application process barriers:

- The application process involves long waits and numerous appointments, indicating a lack of uniform procedures.
- Personal interviews required for eligibility determination and re-determination are not federally mandated.
- Finger-imaging, required in New York to obtain Food Stamps, is inappropriately required of Medicaid applicants.
- Applying for Medicaid in combination with Public Assistance requires multiple appointments in different locations around the city.
- The Eligibility Verification Review process is inconsistent and personally intrusive.
- Medicaid cases are often closed without notification, necessitating re-application.
- More emphasis is placed on detection of fraud and abuse than on getting eligible applicants enrolled.

- The complex and capricious application process requires professional assistance. Without it, applicants are unjustly penalized even when they are eligible for benefits.

The application process is extremely time-consuming, requiring applicants to literally spend days sitting in uncomfortable lobby, waiting for their names to be called. One woman waited three hours at a Medicaid office before she was scheduled for an appointment to return another day and pickup the application. The waiting period for Medicaid can exceed five months, and often applicants must re-apply for themselves and/or their children. Several women from the Bronx spoke of being told by local Medicaid offices that they must wait until they are six months pregnant before applying for Medicaid.

A focus group participant reported that he is a severe diabetic who was homeless at the time he applied for Medicaid. He passed out due to uncontrolled diabetes and was hospitalized. Despite his condition, his application for emergency Medicaid was rejected. He finally received Medicaid only after HRA workers told him to apply for Public Assistance, Food Stamps and Medicaid.

Documentation barriers:

- Stringent documentation requirements are excessively burdensome for homeless applicants and exceed those required by law. The federal Medicaid statute requires only documentation of immigration status and Social Security numbers.
- The mobility of homeless people compounds their difficulty in obtaining and keeping track of many pieces of required documentation.
- Verifying identity, age and Social Security numbers is problematic when applicants don't have original birth certificates or Social Security cards for themselves and each family member.
- Verifying residence is problematic for persons living in shelters or doubled up in apartments where they are technically not permitted to stay and therefore cannot receive mail.
- Verifying income and resources is problematic for applicants who are paid for their work in cash, and when cost of living is not taken into account. Applicants are not legally required to submit documented proof of income and resources.
- Fears of being reported to the INS deter many immigrants from applying for any public benefits for themselves or citizen children. Negative attitudes of Medicaid workers exacerbate these fears, even though Medicaid is not required to report applicants' immigration status to the INS.
- Obtaining documentation of disability status to qualify for Medicaid is a serious problem for homeless persons.

A homeless woman journeyed from her shelter in the Bronx to the Eligibility Verification Review office in Brooklyn by subway. Due to lack of money and available childcare, she brought her toddler in a stroller. She exited the subway at the wrong stop, having to pay another fare before arriving at the correct stop. She then asked for directional assistance from a police officer, who told her she should take a cab. But she had no money for a cab. 'When I got there, I felt like I was going to die. It was that long. I was walking and walking.' ... This experience was extremely frustrating because ... the worker asked for the same information elicited during her face-to-face interview. Participants repeatedly questioned why they must prove their eligibility over and over before applications are approved.

Although one woman had previously received in-hospital Medicaid, she was later denied benefits because she did not have an original birth certificate from the Dominican Republic. She presented a passport from Venezuela where she became a citizen, but it was not deemed acceptable.

Applicants for disability Medicaid are typically individuals who are not eligible for SSI while hospitalized, or those who fall below the \$3000 resource limit for the disability category but exceed the \$2000 resource limit for SSI. Pre-screeners report case after case where doctors attest to an applicant's disability, yet Medicaid does not approve the individual's disability claim.

Recommendations for Legislative Action:

- **Require only documents specified in the federal Medicaid statute** for certification and re-certification.
- **Permit mail-in Medicaid applications and documentation.**
- **Prohibit the personal interview requirement** for certification and recertification.
- **Require recertification no more than once annually** or when circumstances affecting eligibility change.
- **Eliminate the Medicaid assets test**, an option permitted under federal law.
- **Allow presumptive eligibility** for all applicants whose eligibility is not determined within legal time limits.
- **Mandate the availability of language-appropriate forms and applications.**
- **Repeal finger-imaging requirements** for Medicaid applicants and beneficiaries.
- **Eliminate drug and alcohol screening and treatment prerequisites** for eligibility.
- **Mandate regular, intensive training** of all eligibility workers and routine screening of compliance with legal requirements.
- **Mandate provision of assistance** with applications and recertification.

Recommendations for Administrative Action:

- **Design a shorter, simpler application form** for Medicaid-only.
- **Accept the use of expired benefit cards** to verify identity, age, citizenship and Social Security numbers.
- **Increase the number of application sites** where low-income people already receive services.
- **Require workers to provide a receipt** for each document presented.
- **Extend benefits beyond six months** to cover the entire recertification period.
- **Shorten the recertification application and use existing databases** to update documentation, instead of requiring beneficiary to re-submit unchanging information.
- **Increase the acceptability of Letters of Attestation from applicants**, allowing them to present life circumstances as documentation of residence and income.

TENNESSEE

Homeless Health Care Center, Chattanooga, Tennessee

The Homeless Health Care Center (HHCCC) in Chattanooga tracked clients seen in the year 2000 who were not enrolled in TennCare, Tennessee’s expanded Medicaid managed care program that covers 1.3 million Tennesseans including over 560,000 enrollees who do not qualify for Medicaid.

Among TennCare’s 1115 “waiver eligibles” are 120,000 medically vulnerable individuals (“uninsurables”) who cannot obtain private health insurance at any cost. TennCare is unique in its coverage of these individuals, regardless of age or income level, who have been denied private health insurance because of a pre-existing medical condition. Most homeless adults on TennCare qualify as “uninsurable” or as disabled under SSI-Medicaid. A letter of denial from any private health insurance company is sufficient to demonstrate one’s uninsurability. Previously uninsurable TennCare enrollees whose income is above 100% of poverty must pay monthly premiums and co-payments on a sliding scale for all but preventive care.

In addition, all Tennessee children under age 19 whose family income is below 200% of the federal poverty level also qualify for TennCare—a policy that was in place before the state’s CHIP program was approved. Although most homeless children on TennCare are income-eligible for Medicaid, some (particularly fugitives from domestic violence) have family incomes that slightly exceed 100% of poverty.

Of 2,970 homeless patients seen at HHCCC in year 2000, 1,282 (43%) were on TennCare. Only 1% or fewer of the 1688 clients (57%) who were not on TennCare had other health insurance (Medicare or Champus); the remainder had no health insurance. Of the 1282 homeless clients with TennCare coverage at sometime during the year, 693 were newly enrolled, 514 were already enrolled, and 75 lost coverage, leaving a net enrollment of 1207.

**Table D. Homeless Health Care Center, Chattanooga, TN
TennCare status of homeless clients seen in 2000**

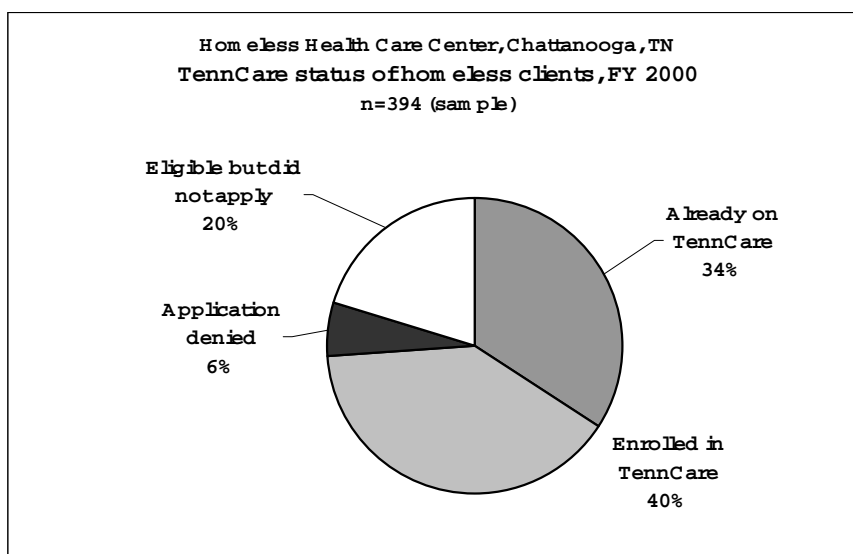
TennCare status	Adults	Children	Total	% Total
Total clients seen	2335	635	2970	100%
On TennCare	838	444	1282	43%
already enrolled	436	153	589	20%
enrolled during year	402	291	693	23%
(coverage terminated during year)	(75)	0	(75)	(3%)
Not on TennCare	1497	191	1688	57%
Did not apply/applied but did not enroll	1422	191	1613	54%
Coverage terminated during year	75	0	75	3%
Presumed eligible but not enrolled*	403	191	594	20%

* based on a sample of 394 clients seen in 2000, 20% of whom were eligible for TennCare but not enrolled

Children under age 18 accounted for 635 (21%) of all homeless patients; 444 (70%) were on TennCare and 191 (30%) were uninsured. Of those on TennCare, 291 (66%) were enrolled or recertified in 2000, and 153 (34%) were already enrolled. The HCH project reported that most of the 191 uninsured children had apparently been previously disenrolled for failure to respond to a recertification notice or when parents lost eligibility for TANF-Medicaid and failed to reapply for TennCare for their children, who remained eligible. Case managers at HHCCC try to find out why their homeless clients are disenrolled, but the TennCare Bureau does not answer their letters of inquiry, despite information requests signed by the patients.

A sample of 394 homeless patients seen by one case manager in FY 2000 was analyzed to determine the percentage of patients who were likely to qualify for TennCare but did not enroll. Of 179 patients who were assisted in applying for TennCare, 156 (87% of applicants, 40% of the sample) were enrolled or re-enrolled, and 23 (6% of the sample) were denied coverage. Applicants were denied for having health insurance in another state, or past-due TennCare premiums (if income exceeded 100% FPL) due to failure to report changes in income after becoming homeless, or for failure to obtain a letter from a private insurer denying coverage for an "uninsurable" condition. The remaining 215 patients did not apply for TennCare—135 were already on TennCare (34% of the sample), and 80 (20%) refused to apply but would have been covered, had they applied.

Extrapolating from this sample, case manager Jord Field predicts that as many as 594 (35%) of clients not on TennCare in FY 2000 (20% of all clients seen) might have qualified for TennCare with comprehensive application assistance. Case managers would have to provide comprehensive assistance to 683 clients to enable 594 (87%) of them to enroll, he estimates.



According to Field, “comprehensive assistance” entails the following efforts on the part of homeless service providers:

- Paying \$25 per client to obtain a letter of denial for private health insurance because of a pre-existing medical condition—the administrative fee charged by insurance companies for generating such letters, which many uninsurable clients cannot afford;
- Maintaining staff to negotiate reconsideration of errors made in the eligibility determination/enrollment process, to obtain medical records when necessary, and to help clients obtain required documentation for enrollment or reverification.

HHCCC noted that the average wait for TennCare coverage following application is 77 days for homeless adults not actively being treated in hospitals or mental health centers, and one day for homeless children, who can obtain expedited enrollment through local health departments. Very few homeless TennCare applicants are being tracked routinely, they report, and most social service agencies do little if anything to assist homeless people with their TennCare applications. As a result, approximately one-third of homeless patients thought to be qualified for TennCare report that they cannot get enrolled.

TennCare Shelter Enrollment Project, National Health Care for the Homeless Council:

Although most homeless children in Tennessee qualify for TennCare, access barriers remain that discourage enrollment and prevent enrolled children from obtaining the services to which they are entitled. For the past two and one-half years, the National Health Care for the Homeless Council has been educating emergency shelter providers across the state to facilitate the enrollment of eligible homeless children in TennCare and monitor their access to primary care.

The TennCare Shelter Enrollment Project is supported by a HUD Emergency Shelter Grant through the Tennessee Department of Human Services, by a grant from the TennCare Bureau of the Department of Finance and Administration, and by the Nashville Metropolitan Health Department. This effort has involved 35 homeless and domestic violence shelters statewide, serving over 5,000 homeless children since July 1998.

Among the project's objectives is to reduce the average percentage of homeless children lacking health insurance at shelter discharge each year compared to the previous year. This objective was met during the project's first two years, through the efforts of trained shelter providers and community-based, interagency workgroups convened by the project coordinator that identified systems barriers to TennCare enrollment and worked collaboratively to help reduce them.

Table E. Health insurance status of sheltered homeless children in Tennessee: July 1998 – December 2000

Health insurance status	Jul 98-Jun 99	Jul 99-Jun 00	Jul-Dec 2000
% uninsured children at shelter admission	18%	11%	16%
% on TennCare at shelter admission	64%	72%	66%
% on TennCare at shelter discharge	73%	80%	78%
% uninsured children at shelter discharge	9%	3%	10%
Total children served	1508	2440	1468

Workgroup participants included shelter providers, MCO representatives, DHS and health department workers involved in Medicaid/TennCare eligibility determination and enrollment, and the TennCare Bureau's coordinator of children's EPSDT services.

A number of enrollment barriers for homeless children have been identified and addressed by participating shelters, by the families residing in these shelters, and by community workgroups. Primary among these are the following:

- **Ignorance of TennCare eligibility criteria**, enrollment procedures and covered benefits;
- **Lack of awareness of expedited enrollment** through health departments;
- **Difficulty filling out applications**;
- **Difficulty satisfying documentation requirements**;
- **Missed communications** about eligibility and enrollment due to lack of a stable address;
- **Difficulty obtaining transportation** to face-to-face interviews; and
- **Long delays between application and enrollment**; families often leave shelters before enrollment is confirmed.

TennCare Shelter Enrollment Project participants have come a long way toward reducing these barriers by

- Convincing local health departments in several counties to implement **expedited (same-day) enrollment** for homeless children;
- Enlisting the **participation of managed care organizations in outreach to shelters** to promote preventive care; and
- Disseminating **TennCare Transportation Service guidelines and schedules** to shelters where homeless families experienced difficulty getting their children to clinical appointments.

TEXAS

Community Health Center of Lubbock, Texas

The Health Care for the Homeless program in Lubbock, Texas, examined electronic encounter data to determine the number of homeless clients lacking Medicaid coverage who had medical diagnoses suggesting that they were probably eligible. Of 2,369 homeless patients served in FY 2000, 599 (25%) were enrolled in Medicaid and 1,770 (75%) were uninsured. Of uninsured clients, 744 (31% of all homeless clients served) had severe mental or physical disabilities likely to qualify them for SSI-Medicaid. These included 218 patients with severe mental illness and 526 with other disabilities including diabetes and kidney problems. Further tracking would be required to determine why these clients did not obtain Medicaid coverage.

**Table C. Uninsured homeless clients likely to qualify for SSI-Medicaid
Community Health Center of Lubbock, Texas, FY 2000**

Category	Number	Percent
Total clients served	2,369	100%
Clients on Medicaid	599	25%
Clients with no insurance	1,770	75%
62. with severe mental illness	218	9%
1. with physical disabilities	526	22%
Total uninsured, disabled clients	744	31%

WISCONSIN

Health Care for the Homeless of Milwaukee, Inc., Milwaukee, Wisconsin:

Health Care for the Homeless of Milwaukee tracked homeless clients seen in FY 2000 who applied for Medicaid but did not enroll. Of 330 clients reported to be on Medicaid by a subset of its provider network, 180 were already enrolled at intake and 162 reapplied at an outstation location; 150 of these applicants (93%) were enrolled without difficulty, and 12 applications (7%) were denied. Of 6,072 total homeless patients seen in FY 2000, 85.1% were uninsured.

Of reported clients who were unable to secure Medicaid coverage but were thought likely to qualify,

1. 38 were persons with severe and persistent mental illness (SPMI);
2. 500 had another chronic health condition thought likely to qualify them for SSI; and
3. 100 were in families that lost Medicaid benefits when eligibility for TANF ended.

**Table I: Probably Medicaid eligible but uninsured
HCH, Milwaukee, FY 2000**

Qualifying Condition	Number	Percent	Eligibility Category
Severe & persistent mental illness	38	6%	SSI-Medicaid
Other chronic conditions	500	78%	SSI-Medicaid or General Assistance*
Children or custodial parents Following loss of TANF	100	16%	Transitional Medicaid or BadgerCare
Total reported	638	100%	

Welfare reform in Wisconsin created some confusion with regard to Medicaid eligibility, according to Lee Carroll, MSW. When custodial parents lost TANF-Medicaid, they were unaware of their children’s continued eligibility under Medicaid, regardless of their own. There was also confusion about eligibility requirements for children and custodial parents under BadgerCare, Wisconsin’s 1115 Medicaid demonstration program that includes the Title XXI (SCHIP) eligibility expansion for children and the Title XIX eligibility expansion for adults.

If homeless people are denied coverage under the State Medicaid plan (which covers all children 0–5 years with family income less than 185% FPL and children 6–14 with family income less than 100% FPL), they may qualify for:

1. **General Assistance Medical Program (GA-MP)** – covers all medical care except mental health services and substance abuse treatment for individuals with income up to \$882/month. Dental extractions are also covered. GA-MP is primarily a resource for single males. One clinic reported 2,157 homeless patients with GA-MP coverage.
2. **BadgerCare** – Medicaid-covered services for children under age 19 and custodial adults with family income up to 185% FPL (no assets limitations) who have no other health insurance;
3. **WisconsinCare** – covers outpatient treatment and inpatient maternity care for persons not eligible for other health coverage, with gross family income up to 150% FPL, who are unemployed or working less than 25 hours per week and are available for full-time work.

Other reasons given for homeless clients’ lack of Medicaid coverage:

5. **Lack of assistance in applying for SSI/Medicaid.**
“Clients who apply for SSI/Medicaid are usually successful if they are working with a nurse or other case manager, but are not as successful if they try to enroll on their own. Usually a case manager or medical provider assists such applicants and advocates for them at the Disability Determination Review, which usually leads to a more positive outcome.”
6. **Lengthy, complex application form and process.**
“The process is too lengthy and the application is too long and complex. It’s difficult for even case managers to understand.”
7. **Ineligible because of a primary substance abuse problem.**
8. **Complex Medicaid spend-down process.**
“The spend down process is so complex that it requires an advocate to assist clients and enable them to maximize this opportunity for coverage, even if on an intermittent basis.”