



NATIONAL  
HEALTH CARE  
*for the*  
HOMELESS  
COUNCIL

October 10, 2011

**Comments on the Centers for Medicare and Medicaid Services' Medicaid Program; Eligibility Changes under the Affordable Care Act of 2010.  
[CMS-2349-P]**

Thank you for the opportunity to submit comments on the changes to Medicaid and CHIP eligibility, enrollment simplification and coordination as a result of the Affordable Care Act. The National Health Care for the Homeless Council is a membership organization comprised of health care professionals, agencies that serve people experiencing homelessness in communities across America, and their patients, many as part of federally qualified health centers (FQHCs). Last year, health centers saw over 1 million patients identified as homeless; while 90% of these patients had income under 100% of the FPL, 65% were uninsured (26% were enrolled in Medicaid/CHIP).<sup>1</sup> Hence, **the expansion of Medicaid in 2014 is of significant importance to us and our patients since many are single adults** and do not qualify for Medicaid under current law.

Those signing onto this letter endorse the aim of these comments and represent other national advocacy and service organizations focused on homelessness and issues related to very low-income individuals, families and children. As a coalition, we are seeking an end to homelessness through access to health care, affordable housing, decent incomes and benefit levels, quality education, and sufficient support services that allow for independent living.

## **BACKGROUND**

**Poor health is a major cause of homelessness and lack of insurance.** An injury or illness can start out as a health condition, but quickly lead to an employment problem due to missing too much time from work; exhausting sick leave; and/or not being able to maintain a regular schedule or perform work functions. Losing employment often means getting disconnected from employer-sponsored health insurance. The lack of both income and health insurance in the face of injury or illness then becomes a downward spiral; without funds to pay for health care (treatment, medications, surgery, etc.), one cannot heal to work again. Of the 1 million personal bankruptcies in 2007, 62% were caused by medical debt.<sup>2</sup> In these situations, any savings accumulated are quickly exhausted, and relying on friends and family for assistance to help maintain rent/mortgage payments, food, medical care, and other basic needs can be short-lived.

Once these personal safety nets are exhausted, there are usually very few options to help with health care or housing.<sup>3</sup> As you well-know, Medicaid is usually limited to children, pregnant women, parents, or

those with a proven permanent disability. Of the 50 million people who are uninsured, 27% are people with low income (<\$25,000 per year).<sup>4</sup> Ultimately, poor health combined lack of employment, little income and no health insurance strongly increases the risk of homelessness.

**Homelessness complicates the ability to engage in treatment and navigate eligibility systems.** When living in shelters or on the street, it is more difficult to arrive for appointments predictably for a variety of reasons. These can include (but are not limited to) the lack of an appointment book or alarm clock, competing needs for locating food and shelter, behavioral health symptoms or illnesses that prevent consistency and/or mobility, and/or lack of bathing facilities that compromise an office-setting presentation. Many of those experiencing homelessness have post-traumatic stress disorder, serious mental health issues, and/or a variety of other factors that cause distrust in people and government systems so they are less likely to self-initiate engagement into treatment and navigate program enrollment processes on their own. Low literacy, cognitive impairments (due to developmental disabilities or to TBI, or both), and difficulty in keeping documentation also contribute to problems navigating systems. Hence, there are numerous barriers for those experiencing homelessness (both individual and systemic) that complicate successful treatment engagement and system navigation.

**Our comments on the proposed rules regarding Medicaid eligibility and enrollment reflect several themes:** agreeing with many provisions that facilitate access to health insurance through simplified methods; ensuring the “no fixed address” option for establishing residency is tied to larger opportunities for data collection and assistance; and ensuring effective redeterminations for those without fixed, stable addresses.

## COMMENTS ON PROPOSED RULES

### ***Changes to Medicaid Eligibility/Individuals Above 133 Percent FPL (§435.218)***

We agree with the proposal to give states the option to extend Medicaid benefits to those with incomes above 133% of FPL. We are highly sensitive to the relationship between low income and the ability to purchase health insurance. The 133% FPL threshold set for Medicaid is certainly not based on livable wages, and no one could reasonably argue that \$14,000 annual income (plus 5% disregard) is sufficient for independent living. States should be free to obtain the cost efficiencies available through higher thresholds.

### ***Changes to Medicaid Eligibility/Amendments to Part 435, Subparts A Through D Parents and Other Caretaker Relatives (§435.110); Pregnant Women (§435.116); Infants and Children Under Age 19 (§435.118)***

We strongly endorse the proposal to simplify and streamline the multitudes of categorical populations down to three categories starting in CY 2014: children, pregnant women, and parents and other caretaker relatives, and making all eligibility based on MAGI (eliminating the resource test). Understanding and navigating health insurance should be as simple and straightforward as possible in order to ensure the fullest participation and access to health care services. Complex rules that separate one population from another based on the finest of details is not only unjust, but serves to further alienate vulnerable populations from engaging in care.

To that end, **we encourage CMS to go further and collapse all these categories into one Medicaid population** (acknowledging different groups have varying FMAP levels). Since eligibility for incomes up to 133% FPL is now common across all groups (with allowances for some targeted populations to be

higher at state option), it would be even more administratively simple to have one eligible population—similar to Medicare Part A and B. While guidance about the service benefits for the newly eligible population has yet to be released, we remain concerned that benefits will vary across groups, leading to gaps in coverage as life circumstances change, confusion about service access, and discrimination based on age or parental status. States would retain the authority to specify those populations that would qualify for additional services, but a common, unified Medicaid foundation has immense appeal for both providers and consumers.

***Point in Time Measurement of Income (Budget Periods) [§435.603(h)]***

We strongly endorse moving to an annual income determination, rather than a monthly one. As the guidance points out, this aligns with other annual eligibility periods for other insurance agreements (the Exchange, as well as most self-insured employer-provided benefits). Many of our patients have income that fluctuates over the course of a year because they are employed for only brief periods of time (e.g., they are engaged in seasonal/day labor, or personal/community economic circumstances prevent holding longer-time employment).

***Residency Definition for Adults Age 21 and Over [§435.403(h)]***

***Residency for CHIP Eligibility [§435.403(i)]***

We are pleased to see that residency for both children and adults will be determined based upon the location they are living and have intent to reside, “including without a fixed address...”. **Individuals experiencing homelessness have significant problems establishing residency** because this often requires having a lease, utility bills, or other stable-housing indicators. Providing mailing addresses of family members or friends who can receive mail is highly unreliable based on tenuous relationships, inability to obtain transportation to receive mail, or an inability to regularly communicate and receive messages. Hence, even those patients who are Medicaid-eligible will often miss re-determination notices and other critical information related to maintaining their health insurance—and subsequently lose coverage (see further comments regarding redetermination below). We want to ensure that the provision expressed in §435.403(i) “as long as each individual has the opportunity to provide evidence of actual residence” is consistent with self-attestation of no fixed address, and does not require paper documentation of a permanent, fixed address.

This provision raises a question with a number of implications. **First, will “no fixed address” be an option on the application form?** By what mechanism will those without fixed, stable addresses be able to indicate “intent to reside,” as the residency definition requires? How will states treat those without housing in a fair and consistent manner that does not jeopardize eligibility and enrollment? Will self-attestation be enough? Will the address of an emergency shelter or post office box be acceptable? We would imagine that the systematic use of third party data would be sufficient to demonstrate “intent to reside” (receipt of food stamps, state disability assistance, or other public benefits the individual may receive; information from correctional facilities, state health institutions/ facilities the individual may have encountered; or information entered into Homeless Management Information Systems).

**Ultimately this is a population that will require more assistance to overcome numerous barriers to enroll in Medicaid and engage in health services; it is imperative we not introduce additional barriers related to lack of address.** We offer our assistance in working with CMS staff on a solution to this issue.

**Second, we strongly encourage the use of a housing status indicator on the application form,** in keeping with the recommendation contained in the U.S. Interagency Council on Homelessness’s Federal

Strategic Plan to Prevent and End Homelessness (which HHS Secretary Sebelius, as an ICH member, endorsed). Specifically, the ICH recommends:

“Create a common data standard and uniform performance measures if feasible, especially related to housing stability, across all targeted and mainstream federal programs. This will facilitate data exchanges and comparisons between both targeted programs and mainstream systems in order to improve identification of people experiencing or at risk of homelessness.”<sup>5</sup>

Capturing housing status of enrollees would assist the state Medicaid agency in a number of ways:

- Identify those who will need additional assistance (e.g., flag for other public assistance programs such as rental assistance),
- Flag this household for possible change in nearest or most appropriate primary care provider/medical home,
- Alert the agency that alternative methods of communicating with the beneficiary are likely needed, and
- Capture information needed at the state level so that housing and health services can be better planned, coordinated, and delivered to vulnerable individuals and families.

**Third, allowing unstable or no fixed addresses is important, but must be coupled with additional allowances to the proposed rules for applications and redeterminations,** as indicated in the comments below.

#### ***Applications (§435.907)***

We re-iterate our comment from above regarding the need to capture information related to housing status on the new single, streamlined application. Since future guidance will clarify the data elements to be used “in collaboration with States and consumer groups,” we respectfully request that the National Consumer Advisory Board (NCAB) be included in this effort. NCAB is an independent advisory body to the National HCH Council comprised of individuals who are currently or formerly homeless, and may be contacted at [ncab@nhchc.org](mailto:ncab@nhchc.org). These perspectives would be invaluable in identifying solutions to traditional barriers to care.

Second, we again encourage CMS to craft applications, forms and other communications with applicants/beneficiaries using language that meets 4<sup>th</sup> or 5<sup>th</sup> grade reading levels. This will help a greater number of people successfully navigate the process on their own, reduce the incomplete or incorrect applications received, and help service providers concentrate on assisting those who are most vulnerable in navigating the application process.

Third, we endorse the proposal to require States to accept applications signed through various techniques (electronic, telephone recording, handwritten, etc.).

#### ***Assistance with Application and Redetermination (§435.908)***

We look forward to the subregulatory guidance that will outline the activities States are to undertake “to conduct outreach to vulnerable and underserved populations eligible for Medicaid” as required under ACA section 1943(b)(1)(F). We regret there have been no resources to date identified for outreach and enrollment for adult populations—as there have been numerous grants provided to states for the enrollment of children into Medicaid and CHIP. We encourage CMS to look for any flexibility possible in using available funds to provide states with resources to engage community-based providers,

community health workers, peer navigators, outreach teams, and others who are trained in locating vulnerable adults who often have significant challenges and live outside mainstream channels of communication. *The National HCH Council offers its technical assistance, training opportunities and published materials to CMS and States in identifying best practices in outreach and enrollment of homeless populations.*

### **Coverage Month**

We agree with the proposed addition to the regulations to “extend Medicaid coverage until the end of the month that the appropriate termination notice period ends.” For our population, termination is often not due to ineligibility, but instead, lack of communication. This additional time not only extends access to health care benefits, but also allows additional days for case managers and other service providers to help correct an inaccurate termination (see comments below on periodic redetermination of Medicaid eligibility, §435.916). Ultimately, we want to eliminate inaccurate terminations and any “churning” between Medicaid and the Exchange.

### **Verification of Income and Other Eligibility Criteria (§435.940 and §435.956) Basis, Scope, and General Requirements (§435.940 and §435.945)**

These proposed rules add language to “expressly permit States to accept attestation of information related to eligibility, including income, age, birth date and State residency, without requesting paper documentation.” We strongly endorse this approach, especially since many of our patients are not in regular possession of personal documentation. We encourage CMS to issue very clear guidelines and requirements to States on this issue, as some states may attempt to introduce barriers to enrollment based on the need for paper documentation.

### **Use of Information and Requests for Additional Information (§435.952)**

We are quite concerned about the provision cited under §435.948(d): “if the individual fails to respond to a request for additional information permitted under the proposed rule, the agency shall proceed to deny, terminate, or reduce Medicaid only after notice and appeal rights have been provided...” . **First we recommend Medicaid be suspended rather than terminated**, particularly when the infraction is based on lack of response rather than a substantiated reason why the individual is no longer eligible for Medicaid. **Second, we recommend the application form contain alternative options for communication** (such as personal email) or allow a third party email/phone number (such as a case manager or primary care provider) as a “back up,” especially when there is a “no fixed address” indicator present.

### **Periodic Redetermination of Medicaid Eligibility (§435.916)**

We agree that 12-month eligibility, with all types of renewals based on third-party data matching without requiring any further action from the beneficiary, is the best approach to achieve administrative simplicity for States and to facilitate access to benefits for the majority of patients and providers. However, for individuals experiencing homelessness, we are concerned that third-party data matching, especially for people who generally fall below the filing threshold, will be unreliable. In these cases, the proposed rule stipulates that CMS will send out a pre-populated form to the beneficiary and will require a response within 30 days (in person, online, by telephone, or by mail). For many of our patients, receiving written communication at any indicated address is highly unreliable—responding within 30 days is often difficult due to the instability associated with homelessness. **We recommend that CMS consider an alternative methodology (e.g., an emailed copy to the beneficiary as well as other “back-**

**up persons” with an extended deadline), especially if “no fixed address” or some other housing stability data element, indicated that receiving mail may be difficult.**

In addition, **we recommend that CMS issue clear guidance to states requiring a suspension of Medicaid eligibility rather than termination for those individuals who are incarcerated.** We would also ask that CMS encourage states to include their corrections systems in planning processes and in optional data matching protocol. Those who are re-entering communities after incarceration face innumerable barriers to obtaining employment, housing, and health care. The Medicaid expansion offers an opportunity to ensure Medicaid eligibility is active at the point of exit, which allows community providers to make better transitions of care. Ideally, these systemic improvements have the potential to reduce recidivism and improve health outcomes.

***Internet Web Site [§435.1200(d)]***

We agree that accessibility for those who are disabled and have limited English proficiency is important and appreciate CMS accommodation in this regard; however, we encourage CMS to consider limited literacy as a functional impairment/disability and design the website to enable those with 4<sup>th</sup> and 5<sup>th</sup> grade reading levels to navigate effectively.

We appreciate CMS’ clear intent to create a “culture of coverage” when designing the Medicaid expansion. As health care providers, we are especially excited for our patients to be able to access the comprehensive health care services they so desperately need. We look forward to continuing to work with CMS on the implementation of the ACA, and again offer our technical assistance on outreach and enrollment and make the National Consumer Advisory Board available for a focus group on the application. Please do not hesitate to contact me to discuss these comments further. I can be reached at [jlozier@nhchc.org](mailto:jlozier@nhchc.org) or at 615-226-2292.

Respectfully submitted,

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Executive Director

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<sup>1</sup> Health Resources and Services Administration (HRSA). 2010 Uniform Data System Report. Available at: <http://bphc.hrsa.gov/uds/view.aspx?year=2010&prog=TOT>.

<sup>2</sup> Himmelstein DU, Thorne D, Warren E, , Woolhandler S. (February 2009.) “Medical Bankruptcy in the United States, 2007: Results of a National Study.” *The American Journal of Medicine* 122 (8): 741-746.

<sup>3</sup> Lewis, J.H., Andersen, R.M., & Gelberg, L. (2003). Health care for homeless women. *J Gen Intern Med*,18(11): 921-928.

<sup>4</sup> DeNavas-Walt, C., Proctor, B.D., & Smith, J.C. United States Census Bureau. “Income, Poverty, and Health Insurance Coverage in the United States: 2010”. Issued Sept 2011. p. 60-238. Available at: <http://www.census.gov/prod/2011pubs/p60-239.pdf>.

<sup>5</sup> U.S. Interagency Council on Homelessness. (June 2010.) Opening Doors: Federal Strategic Plan to Prevent and End Homelessness. Washington, DC.: 35. Available at: [http://www.usich.gov/opening\\_doors/](http://www.usich.gov/opening_doors/).

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**ENDORISING ORGANIZATION SIGNATURES BELOW:**