

Medicaid: Tools and Information for the Fight Against Homelessness

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Presentation Overview

- 9-10:30
 - Introductions
 - General overview of Medicaid, health care reform, and related policy issues
- 10:30-10:45
 - BREAK
- 10:45 – Noon
 - Advocacy opportunities and connecting with Medicaid

Tell us about you

- How many of you are current Medicaid providers?
- How many of you work for a state or federal agency?
- How many of you are primarily (or only) funded through grants or other non-insurance based funding streams?

Pop Quiz

1. Medicaid is a:
a) Federal program b) State program c) Both
2. The Medicaid program began in:
a) 1965 b) 1929 c) 1985 d) 1970
3. State participation in Medicaid is:
a) Voluntary b) Mandatory
4. ACA stands for:
a) Accountable Care Act b) Affordable Care Act c) America Cares Act
5. When can a state begin covering non-disabled single adults under their Medicaid program?
a) 2014 b) Now c) 2012 d) Never unless the law changes

Pop Quiz

6. How many new people are estimated to be enrolled in Medicaid by 2014?
a) 16-22 million b) 5-8 million c) 60-65 million d) 100-200 million
7. People receiving SSI are automatically eligible for Medicaid in every state.
a) True b) False
8. States will be required to cover single adults with incomes up to what percent of the Federal Poverty Level by 2014?
a) 200% b) 100% c) 138% d) 180%
9. The Medicaid program was signed into law by what President?
a) Obama b) Kennedy c) Carter d) Johnson
10. What is the federal agency with oversight of the Medicaid program called?
a) HCFA b) SAMHSA c) HRSA d) CMS

Medicaid and Homelessness

“Why should any housing or services provider consider affiliating with Medicaid? Because quite frankly, it’s our greatest chance to make the biggest difference for the most people to move the needle on all of homelessness.”

-- HUD Secretary Shaun Donovan at the National Alliance to End Homelessness Annual Conference, July 30, 2009

Medicaid and Homelessness

“Health reform generally, and Medicaid expansion in particular, is the secret weapon in the fight against homelessness.”

-- Jennifer Ho, Deputy Director at the US
Interagency Council on Homelessness

Medicaid and Homelessness

“The Affordable Care Act...will further the Plan's goals by helping numerous families and individuals experiencing homelessness to get the health care they need.”

-- *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness*

Why is Medicaid Important?

- **It Can Help Homeless People be More Successful in Housing**
 - Meeting health and behavioral health needs allows many people to stabilize and move directly from homelessness into housing.
- **It Can Help Prevent Homelessness**
 - Being enrolled in Medicaid can help people address a costly health crisis which can prevent a household from having financial troubles and being at risk of homelessness.
- **It Can Help Redirect Housing Resources Back to Housing**
 - Agencies can shift the cost of providing Medicaid reimbursable supportive services from HUD to Medicaid.
- **It Can Save Money**
 - Studies have documented that helping homeless people in the community is more cost-effective than providing services in expensive public settings – such as hospitals, jails, mental health facilities, and institutions.
- **It Can Lead to Homeless Agencies Receiving Additional Housing Funds**
 - The Federal government has prioritized linking people who are homeless to Medicaid, including increased HUD resources to communities that demonstrate strong linkages.
- **It Can Do Even More!**
 - Changes resulting from new health care reform make Medicaid even more effective at preventing and ending homelessness.

Medicaid Can...

- **Help homeless people be more successful in housing**
 - People who are homeless frequently report health problems and homelessness inhibits care
 - Housing instability detracts from regular medical attention, access to treatment, and recuperation
 - Inability to treat medical problems can aggravate these problems, making them both more dangerous and more costly
 - If left untreated, these problems can be barriers to finding housing and maintaining it and can get worse over time
- Homeless providers have successfully used Medicaid to provide supports in permanent housing
 - Maine uses Medicaid reimbursable services to help over 850 homeless S+C participants be stable in housing
 - Medicaid covers mental health services, counseling, detox, transportation, case management, primary health, etc.
 - Medicaid = entire required S+C match

Medicaid Can...

- **Help prevent homelessness**
 - For persons without medical insurance, experiencing a major medical event could result in being forced to choose between paying for a place to live or medical care
 - In 2007, 62% of personal bankruptcies were due to high medical debt
 - Anecdotal results from HPRP interventions indicate that health care is one of the main causes of homelessness

Medicaid Can...

- **Help redirect housing resources back to housing**
 - McKinney-Vento (M-V) grantees and sponsors can use Medicaid funding to cover the cost of some HUD-funded services. Using the reallocation option, M-V grantees can then reallocate funding from SHP services programs to new permanent supportive housing
 - Example: Long Island Shelter (Boston) is qualified to bill Medicaid for health care, assessment, and clinical management for eligible homeless M-V participants

Medicaid Can...

- **Save money**

- In Boston, over a five year period, a cohort of 119 street dwellers accounted for 18,384 emergency room visits and 871 medical hospitalizations
 - Average annual health care cost for 119 CH individuals living on the street was \$28,436, compared to \$6,056 for individuals in the cohort who obtained housing
- In a NY study, following placement in PSH, homeless people experience fewer and shorter psychiatric hospitalizations, a 35% decrease in the need for medical and mental health services and a 38% reduction in costly jail use
 - PSH costs offset by savings in governmental spending on health services for this population

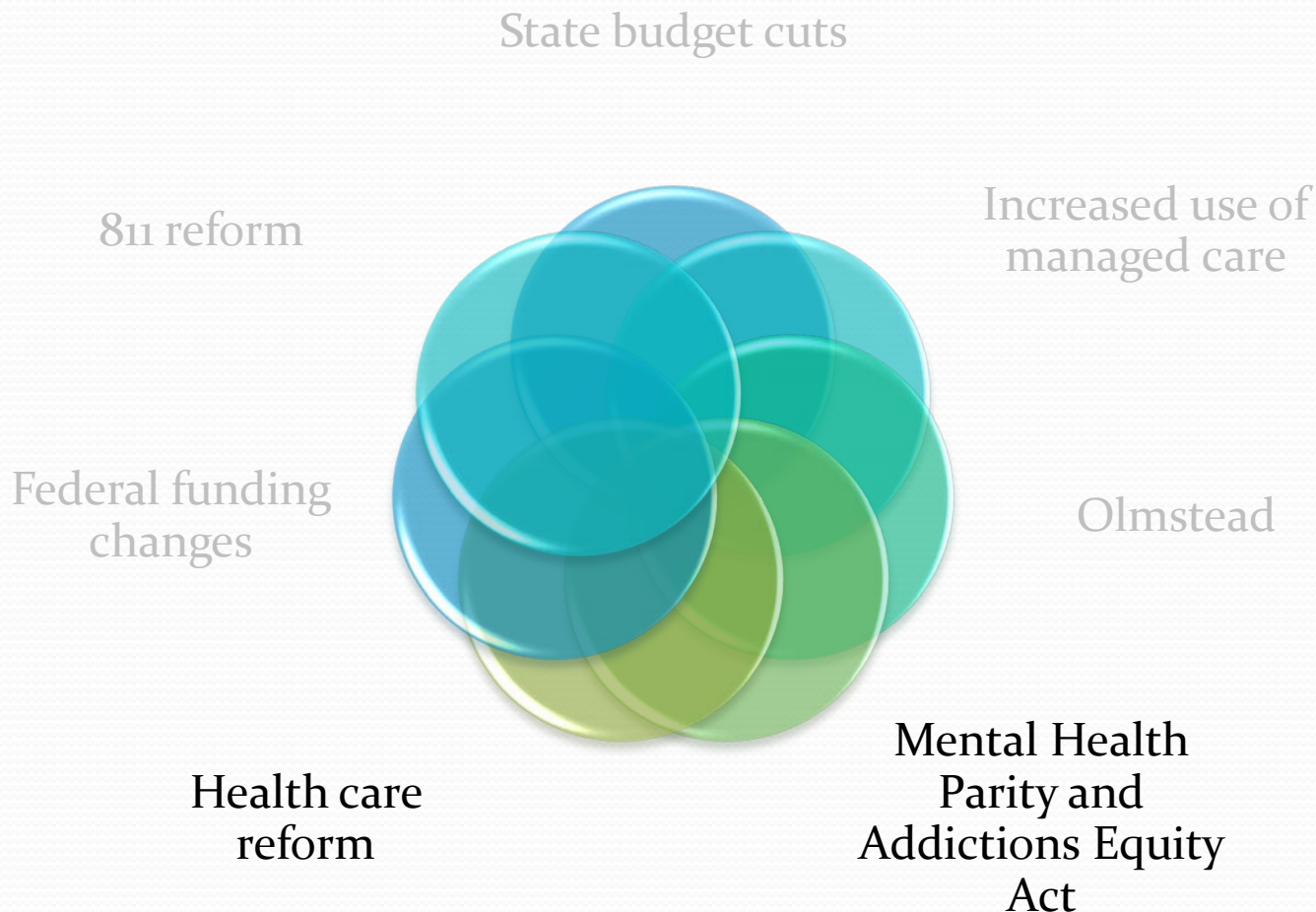
Medicaid Can...

- **Help Sustain Valuable Homeless Programs**
 - Especially if the grant requires sustainable strategies and requires linkages with mainstream funding sources from the start
- HUD/HHS/VA grant in Ohio with funding to provide permanent housing to 156 chronically homeless individuals
 - HUD funded rental costs
 - HHS paid for services, but HHS funding was designed to decrease over time of the grant
- To reduce dependence on HHS Service Grant funding, the grant was designed to have Medicaid cover services including:
 - Assertive Community Treatment services
 - Reimbursement for behavioral health services
 - Reimbursement for partner agency service activities that are provided to program recipients but were not being billed to Medicaid

Medicaid and the ACA

Medicaid and health reform 101 for providers of services for people who are homeless

Policy Context



Medicaid is...

- The government funded health insurance program for low-income Americans established in 1965 as part of President Johnson's "War on Poverty"
- Jointly funded by the states and the federal government
- Administered by the states within broad federal guidelines
- Changing as a result of health care reform

Medicaid 101

- Federal government reimburses states for half or more of their Medicaid costs
- States have significant discretion about:
 - Who is covered
 - What services are covered
- Medicaid is an entitlement, but individuals must apply and be determined eligible
 - Approximately 50 percent of homeless people presumed eligible for Medicaid were not receiving it
- Must also go through a re-determination process each year to continue to be enrolled
 - Some states require that people go through the process more often than annually

**If you've seen one Medicaid program,
you've seen one Medicaid program.**

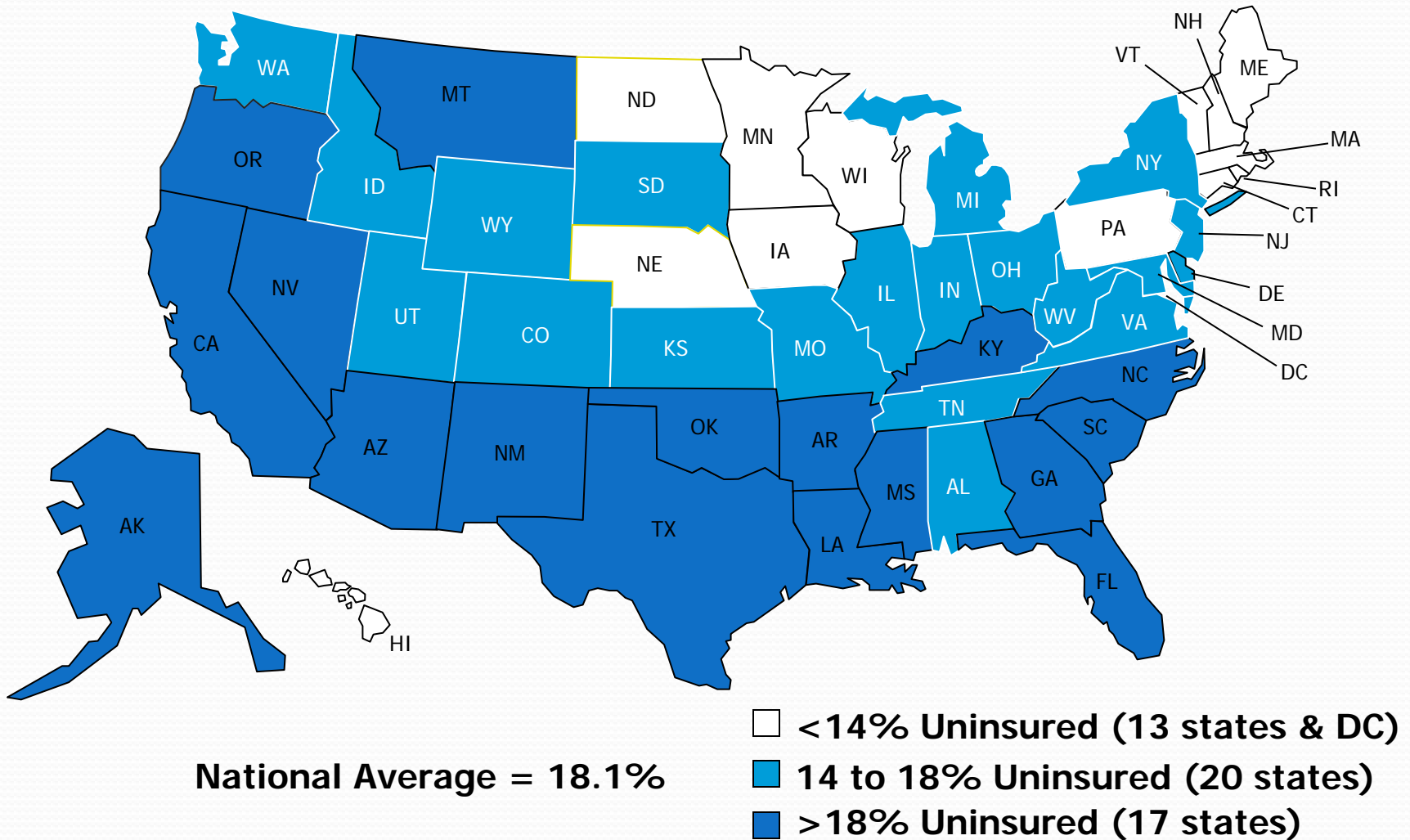
The Affordable Care Act...

- Expands Medicaid eligibility
- Reduces barriers to Medicaid enrollment
- Gives states more options for covering community-based long-term care services that can help people who are homeless obtain and sustain housing
- Improves access to mental health and substance use disorder services
- Authorizes funding for public health programs and mental health / physical health integration programs that will benefit people who are homeless

ACA Medicaid Eligibility Expansion

- Expands eligibility to single adults under 65 with incomes up to 138% of the Federal Poverty Level
 - Most people who are homeless will be eligible for Medicaid
 - Estimated that 16-22 million people will become eligible for Medicaid under the expansion
- Extends Medicaid to individuals under 26 who have aged-out of child welfare
- States must enact these changes by 2014 but.....
 - States can enact these changes sooner
- States will receive a higher federal match to pay for the cost of this expansion
 - Federal match will be 100% of the costs associated with the expansion for the first three years, with the percentage gradually decreasing to 90% by 2020

Uninsured Rates Among Nonelderly by State, 2008-2009



SOURCE: Kaiser Commission on Medicaid and the Uninsured/Urban Institute analysis of 2009 and 2010 ASEC Supplements to the CPS., two-year pooled data.

Current Federal Medicaid Eligibility

Categorical Criteria

- Pregnant women
- Infants/Children
- Aged, Blind, Disabled
- Families with dependent children

Financial Criteria

- Income levels
- Assets and other income

New Eligibility Group Under ACA

Financial Criteria Only

- Single adults under 65
- Incomes up to 138% of the Federal Poverty Level

Single adults under 65 are eligible for Medicaid
based on **income alone**

ACA and Benchmark Plans

- For the newly eligible “expansion population” states only have to offer a “benchmark” or equivalent plan
- Must cover FQHC services, rural health services, EPSDT services for youth under 21, prescription drugs and treatment for **MH/SUD at parity**.
- Note: Parity does not mean access to good MH & SUD benefits; it means that MH & SUD are treated similarly to physical health (PH) benefits
- Still important to advocate for a good benefit package

ACA and Benchmark Plans

- Certain individuals cannot be required to enroll in a benchmark plan including:
 - Pregnant women
 - Dually eligible
 - Aged, blind, disabled
 - Youth in foster care or those receiving adoption assistance
 - **Medically frail and special medical needs individuals-- includes persons experiencing MI and children with SED**
 - Individuals eligible for TANF



Helping people who are homeless pursue SSI as a pathway to Medicaid enrollment remains important under health reform!

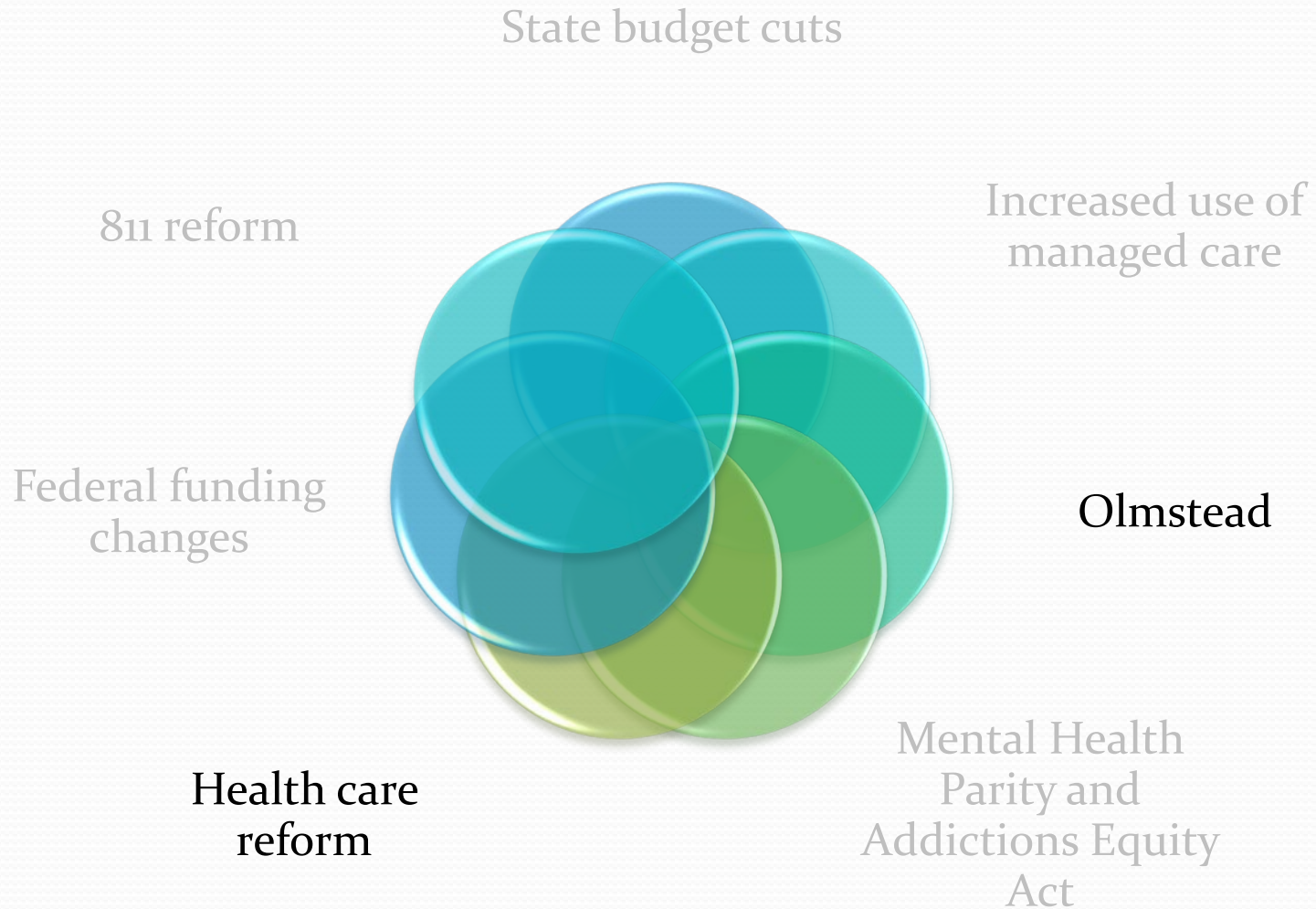
Presumptive eligibility

- As of 2014, Section 2202 of the ACA permits hospitals that are participating Medicaid providers to make presumptive eligibility determinations
- This will allow people who are homeless who are in need of treatment to go to a participating hospital, and become “temporarily” eligible for Medicaid
- Hospitals do not have participate
- States will need to make sure they have systems in place to allow hospitals to make these determinations

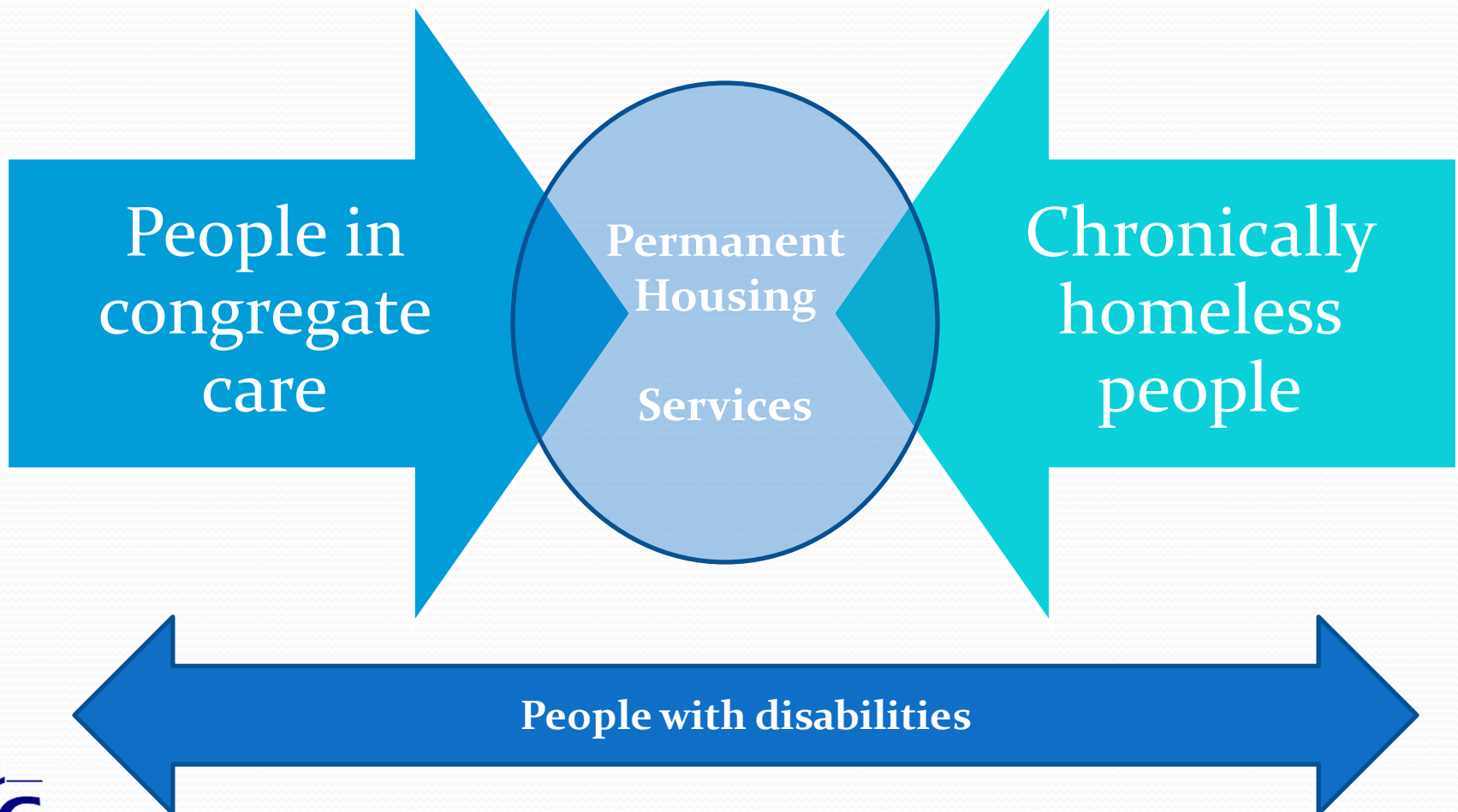
Implications for service providers and advocates

- Eligibility does not equal enrollment
 - **Influence** the state's enrollment and outreach plan; **support and monitor** implementation
- More people with coverage; increased access to care
 - **Influence** outreach materials and member information
- More people seeking treatment, can the service system keep up with demand?
 - **Learn** about access requirements and monitor access issues

Policy Context



Why Talk about Health Reform and Long Term Care?



Why Talk about Health Reform and Long Term Care?

- The current system discriminates against people with disabilities: there is very little truly affordable housing, and access to needed community services and support is very limited.
- The result is that people with disabilities have to make a choice between living in restricted congregate care (nursing home, board and care home, group home), or becoming homeless.
- Some default to homelessness because they refuse to give up their rights by moving into a restricted setting.
- Health/long term care reform is the only way to change this equation.

Data

- Nationally, over 412,000 non-elderly people with disabilities reside in nursing homes
- About 125,000 non-elderly people with mental illness live in nursing facilities – an increase of 40% since 2002: these individuals are costing federal/state Medicaid programs over \$6 billion per year
- Medicaid pays over \$100 billion annually for institutional care – nearly 75% of all Medicaid long term care expenditures for elders and people with disabilities is for institutional care
- In a recent analysis of state SSI data conducted by TAC, 12 states were paying an average of \$33,000 per year to subsidize almost 90,000 people with disabilities placed in board and care facilities

Olmstead

- June 22, 2009 President Obama declares “The Year of Community Living”
 - DOJ increases enforcement of Olmstead with investigations and/or lawsuits occurring in:
 - Delaware (2010)
 - New Hampshire (2011)
 - Virginia (2011)
 - New York (Disability Advocates, Inc. v. Paterson)
 - Georgia (U.S. v. Georgia)

ACA: Long-Term Care Opportunities

- Changes to 1915(i) Home and Community-Based Services State Plan Option
- Health Homes for Individuals with Chronic Conditions
- Rebalancing Incentive Program
- Community First Choice Option
- Extends and increases funding for Money Follows the Person (MFP) demonstration
- Increased funding for Aging and Disability Resource Centers (ADRC)

Policy Context

State budget cuts

811 reform

Increased use of
managed care

Federal funding
changes

Olmstead

Health care
reform

Mental Health
Parity and
Addictions Equity
Act



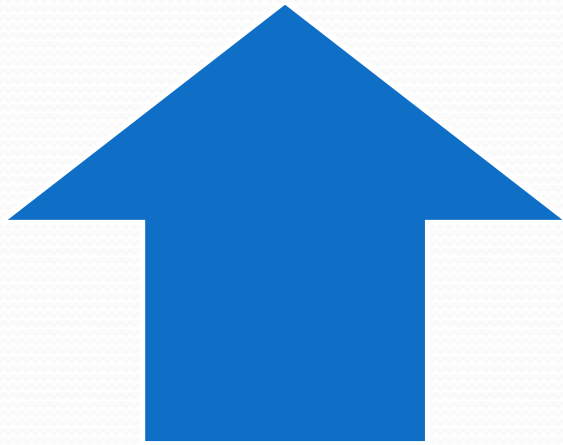
State budgets in crisis

States with the largest cuts by percentage of their overall state mental health general fund budget from 2009 to 2011.

- Alaska 35%
- South Carolina 23%
- Arizona 23%
- Washington, D.C. 19%
- Nevada 17%
- Kansas 16%
- California 16%
- Illinois 15%
- Mississippi 15%
- Hawaii 12.1%

Source: NAMI (2011). State Mental Health Cuts: A National Crisis.

State Medicaid Financing



Enrollment



State
budgets

State Medicaid Financing

State	Loss of Enhanced Medicaid Match FY 2012* (in millions)
Alabama	\$133
Alaska	\$57
Arizona	\$353
Arkansas	\$129
California	\$1,881
Colorado	\$159
Connecticut	\$204
Delaware	\$48
District of Columbia	n/a
Florida	\$794
Georgia	\$234
Hawaii	\$90
Idaho	\$53
Illinois	\$553
Indiana	\$239
Iowa	\$112
Kansas	\$87
Kentucky	\$159
Louisiana	\$395
Maine	\$88
Maryland	\$290
Massachusetts	\$501
Michigan	\$379
Minnesota	\$282
Mississippi	\$151
Missouri	\$297
Montana	\$40

State	Loss of Enhanced Medicaid Match FY 2012* (in millions)
Nebraska	\$63
Nevada	\$79
New Hampshire	\$54
New Jersey	\$408
New Mexico	\$134
New York	\$1,407
North Carolina	\$343
North Dakota	\$22
Ohio	\$514
Oklahoma	\$203
Oregon	\$156
Pennsylvania	\$668
Rhode Island	\$74
South Carolina	\$148
South Dakota	\$23
Tennessee	\$239
Texas	\$851
Utah	\$58
Vermont	\$39
Virginia	\$293
Washington	\$338
West Virginia	\$81
Wisconsin	\$228
Wyoming	\$23

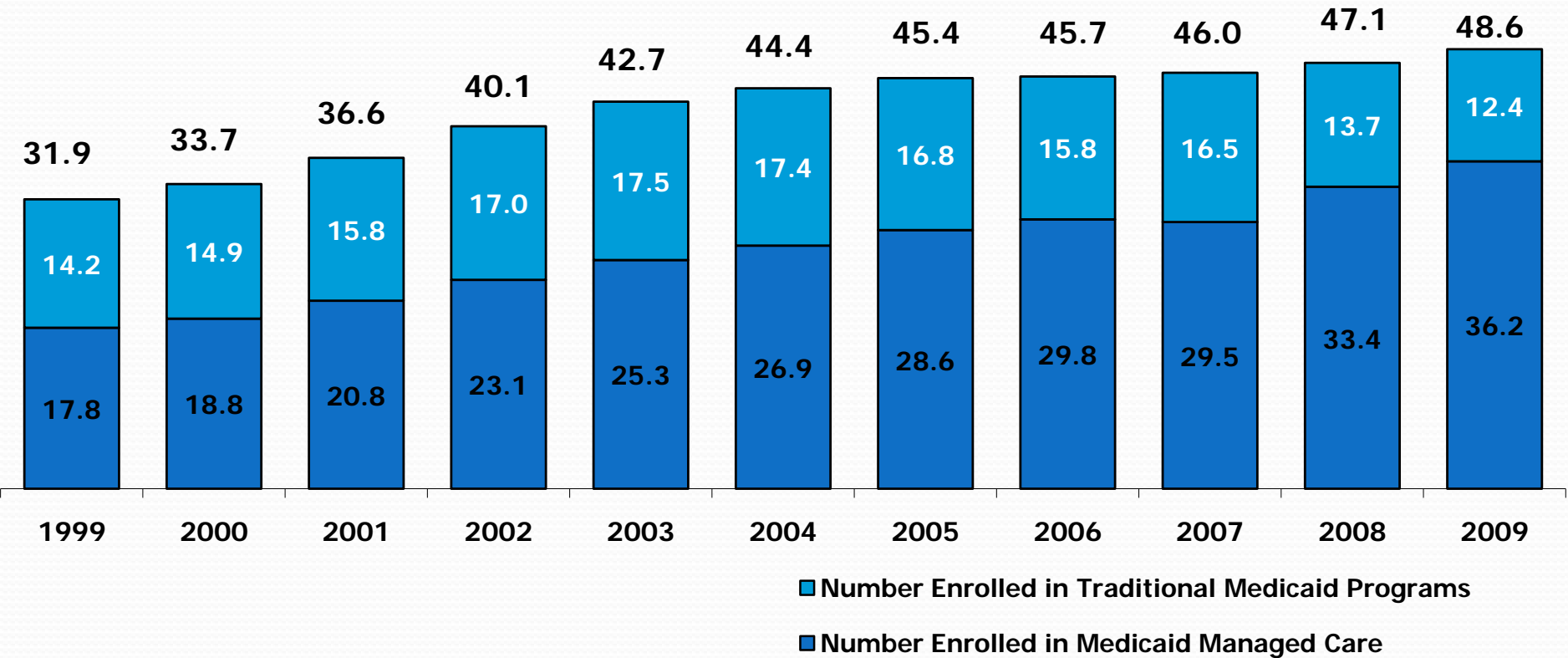
Source: NAMI (2011). State Mental Health Cuts: A National Crisis.

Why do public purchasers choose managed care?

- Cost-containment potential
- Cost savings
- To use tools to improve provider performance and quality of care
- Perform administrative/management functions
- To focus on service development
- Eligibility expansions

Medicaid Managed Care and Traditional FFS Enrollment, 1999-2009

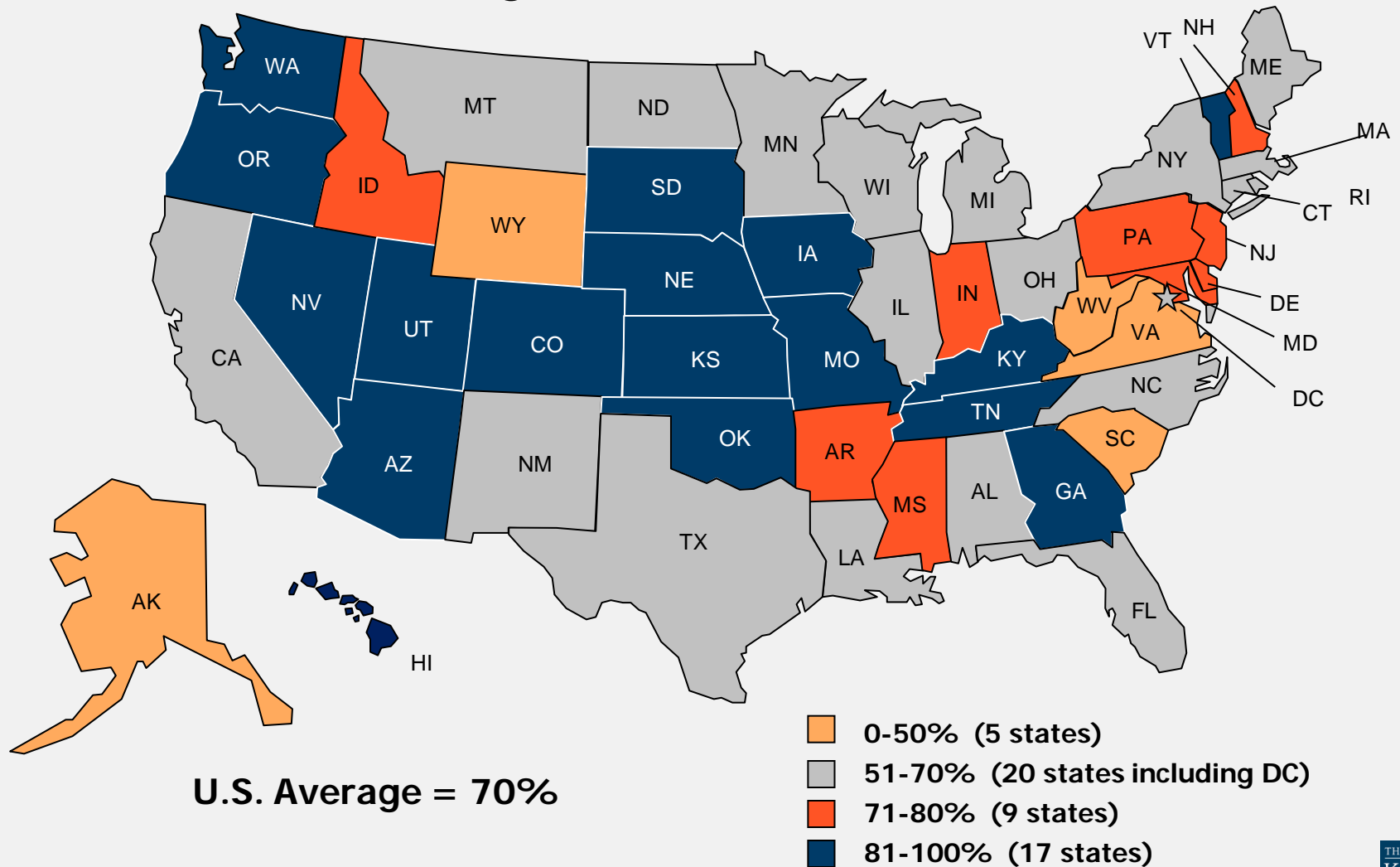
Enrollment (in millions)



Note: Numbers may not produce totals because of rounding. Unduplicated count. Includes managed care enrollees receiving comprehensive and limited benefits.

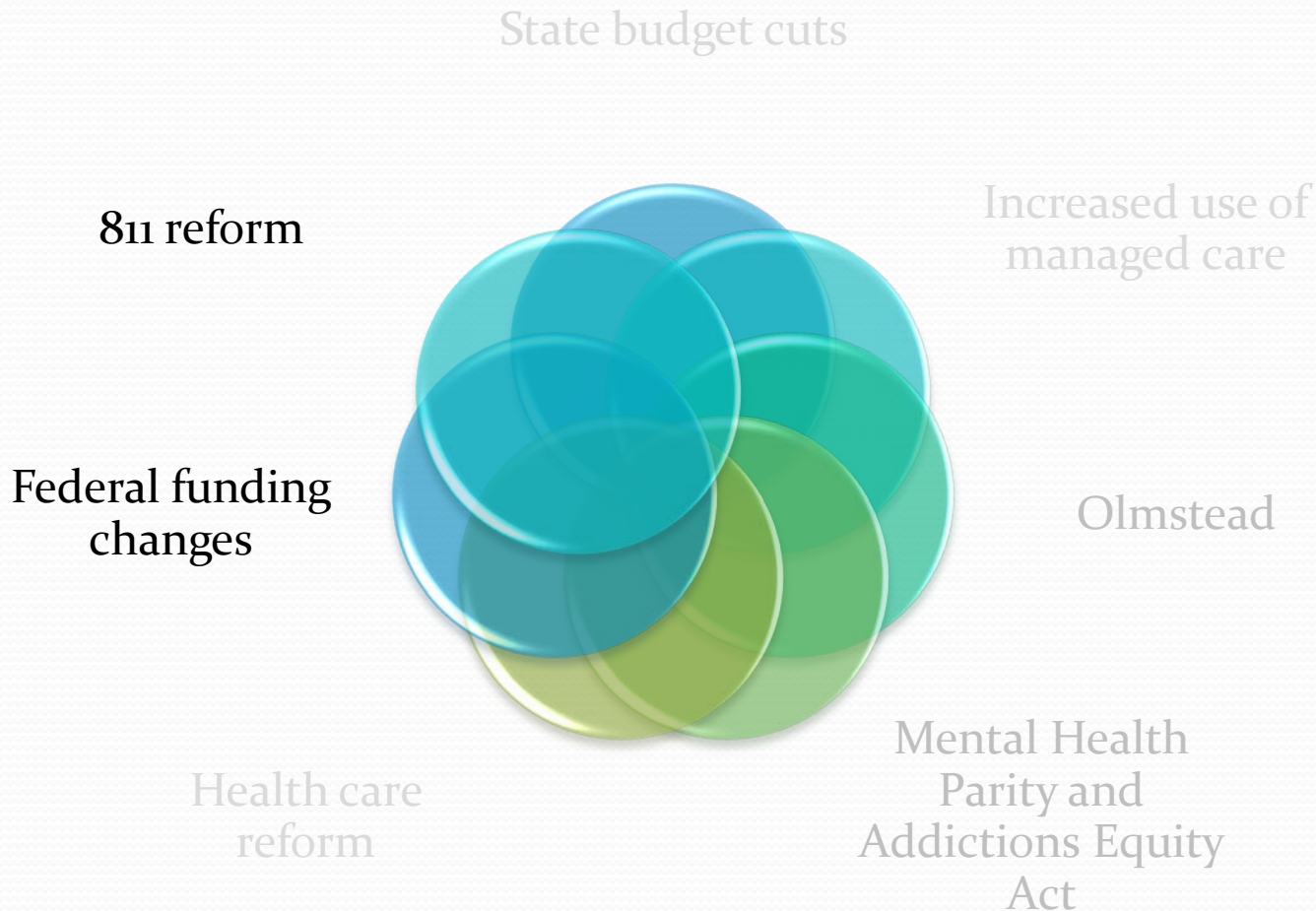
SOURCE: 2009 Medicaid Managed Care Enrollment Report. CMS.

Medicaid Managed Care Penetration Rates by State, 2008



Note: Unduplicated count. Includes managed care enrollees receiving comprehensive and limited benefits. SOURCE: Medicaid Managed Care Enrollment as of December 31, 2008. Centers for Medicare and Medicaid Services.

Policy Context



Connections with Medicaid



Frank Melville
Supportive
Housing
Investment Act of
2010



CoC



Changes to
SAMHSA block
grants



Cooperative
Agreements to
Benefit Homeless
Individuals
(CABHI)



Frank Melville Supportive Housing Investment Act of 2010

- Reforms HUD's Section 811 Supportive Housing for Persons with Disabilities program
- Bipartisan legislation signed into law on January 4, 2011
- Modernizes and reforms the Section 811 program by:
 - Emphasizing integrated housing models
 - Creating incentives to link Section 811 rent/operating subsidy funding to other sources of affordable housing capital (tax credits, HOME funds, etc)
 - Implementing new 811 option targeted to state housing agencies and state Medicaid agencies

Reformed Section 811 Program

1. Reforms existing 811 Capital/PRAC program
2. Shifts appropriations for 811 tenant based voucher program (14,000 vouchers) to the Section 8 appropriation
 - Vouchers remain targeted to people with disabilities
3. Creates new Section 811 Project-Based Rental Assistance option to leverage integrated affordable housing units financed with mainstream housing funding (tax credits, HOME funds, etc.)
 - Cross-disability approach focused on priority Medicaid populations

Could fund 3,000 - 4,000 new units annually

How Will New Section 811 PRA Option Work?

- State HFA must enter into an agreement with the State Medicaid/Health and Human Services agency which:
 - Identifies the target populations to be served by the project
 - Sets forth methods for outreach and referral
 - Makes available appropriate supportive services for tenants of the project
- Within 3 years of enactment, HUD must report to Congress on the effectiveness of this new approach

Federal Policy and Funding

- Since 2002, HUD measures homeless providers ability to link homeless participants to Medicaid and other mainstream resources
 - Required component of a CoC's McKinney-Vento NOFA
 - Impacts CoC's score, which can impact the amount of M-V funding a CoC receives

Federal Policy and Funding

Cooperative Agreements to Benefit Homeless Individuals (CABHI)

- SAMHSA requires funded grantees **to provide proof** they are qualified to receive Medicaid reimbursements and they have a reimbursement system that has been in place for a minimum of one year prior to the date of application or have established links to other behavioral health or primary care organizations with existing reimbursement systems for services covered under the state Medicaid plan
- These efforts will both support the long-term sustainability of permanent housing programs in the community and will help communities prepare for Medicaid coverage expansion to all low-income adults up to 133% of the Federal Poverty Level in 2014.

SAPTBG and MHSBG Changes

- SAMHSA Block grant funds will be directed toward four purposes:
 1. To fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time
 2. **To fund those priority treatment and support services not covered by Medicaid, Medicare or private insurance or for whom coverage is terminated for short periods of time**
 3. To fund primary prevention
 4. To collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment, and recovery support services

Implications for service providers

- Cannot rely on grant or philanthropic funding alone
 - Diversification of funding streams is necessary to survival
- Becoming Medicaid and managed care “competent” is no longer an option
- Developing formal relationships with FQHCs and other Medicaid providers is critical

Break

15 minutes

Advocacy opportunities and connecting with Medicaid

Tips and tools for advocates

Leveraging and Influencing Medicaid

Macro

- Benefit design
- Access / enrollment
- Delivery system
- Provider qualifications

Micro

- Provide services
- Facilitate enrollment

Taking Action

- Get to know your “Single State Medicaid Agency”
- Encourage the development of cross-disability coalitions between housing and human services providers—strength in numbers
- Identify policy priorities at local, state and federal levels that align with goals of PSH (e.g. Olmstead, reducing health care disparities)
- Encourage cross-system partnerships at state and federal levels

Engaging policy leaders

- Know your “ask” – have only 2-3 items for discussion
- Have data and personal stories
- Prepare for all sides of the issue
- Power of coalition—who else shares your perspective?
- What if the answer is “no”
- Ask how you can help make “the ask” a reality
- Identify next steps, including whom on their staff you can work with

Taking Action on ACA

- **Eligibility –**

- Inform the development and implementation of the outreach, notification, and enrollment activities to best meet the needs of individuals who are homeless or at risk of homelessness.
- More people seeking treatment, can the service system keep up with demand?
 - **Learn** about access requirements and monitor access issues

- **Benefit design**

- Benchmark versus standard benefit
- Inclusion of HCBS benefits under the State's Medicaid plan

Taking Action on ACA

- **Respond** to requests for public comment on proposed regulations
- Take advantage of ACA provisions designed to:
 - Support **public health activities**
 - Promote **integration of physical and behavioral health care**
 - Strengthen and expand the available **health care workforce**

Leveraging and Influencing Medicaid

Macro

- Benefit design
- Access / enrollment
- Delivery system
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Micro

- Provide services
- Facilitate enrollment

Connecting with Medicaid

Option 1

- Become a Medicaid provider

Option 2

- Subcontract

Option 3

- Make connections

Option 1: Become a Medicaid Provider

Step 1

- Get to know the single state Medicaid agency

Step 2

- Learn about what services are covered and who is eligible to provide those services

Step 3

- Take an inventory of the services your organization offers and if your organization meets the provider qualifications

Step 4

- Learn about the necessary provider infrastructure

Step 5

- Gathering materials to apply



Step 1

Get to know the Medicaid agency

Get to know the Medicaid agency

- Leadership
- Eligibility
- Provider enrollment process and system
- Delivery system
 - Traditional fee-for-service
 - Managed care
 - Long-term care services
 - Home and community-based services waivers – 1915(c)

Structure of Behavioral Health Benefit in Managed Care

Integrated


- One plan manages both physical and behavioral health benefits

Subcontracted

- One plan is responsible for both physical and behavioral health benefits but subcontracts management of behavioral health to another entity

Separate

- Different entities are responsible for physical health and behavioral health benefits; with variation in contractual obligations to coordinate care/work together



What do you know about your
Medicaid agency?

Step 2

Learn about what services are covered and who is eligible to provide those services

Medicaid “State Plan” Services

Mandatory

- Inpatient/outpatient hospital
- Prenatal care
- Vaccines for children
- Physician services
- Nursing facility for persons aged 21 or older
- Family planning services and supplies
- Rural health clinic
- Home health care for persons eligible for skilled-nursing services
- Laboratory and x-ray services
- Pediatric and family nurse practitioner services
- Nurse-midwife services
- FQHC services
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for children under 21

Optional

- Diagnostic services
- Clinic services
- Intermediate care facilities for the mentally retarded (ICF-MR)
- Prescription drugs and prosthetic devices
- Optometrist services and eyeglasses
- Nursing facility services for children under 21
- Transportation services
- Targeted case management
- Rehabilitation and physical therapy services
- Home and community-based services for individuals with chronic conditions
- Hospice care
- Dental care

All Medicaid services are subject to **medical necessity** standards that are developed by the states under federal guidelines.

Home and Community-Based Waiver Services: State Example -- CT

Acquired Brain Injury Waiver

- Case management
- Homemaker services
- Personal care
- Prevocational counseling
- Supported employment
- Respite
- Community living support
- Home delivered meals
- Independent living skill training
- Cognitive behavioral programs
- Substance abuse program
- Transitional living
- Vehicle modifications
- Chore services
- Environmental accessibility adaptations
- Transportation
- Personal Emergency Response System
- Live-in caregiver
- Specialized medical equipment

Medicaid Services

Qualified

Individual

Provider

Practitioner

Service

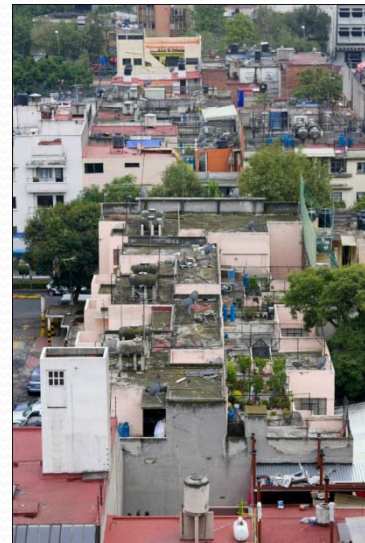
Medicaid Services

- For each service you need to learn about:
 - Who is eligible for the service?
 - Medical necessary criteria
 - What are the necessary provider qualifications?
 - Provider type(s)
 - Practitioner qualifications
 - Where can the service be performed?
 - How must the service be performed?
 - What is the current rate for the service and in what increments is the service billed?

How do I learn what is covered?

- State Medicaid plan and amendments
- State Medicaid provider manuals
- Managed care company provider manuals
- Member handbooks
- Websites for Medicaid agency and State Mental Health and Substance Use authorities
- Calls/meetings with Medicaid or managed care staff
- Talking with established Medicaid providers
- Interviews with advocacy organizations (e.g. NAMI) or trade organizations

What are the types of services and supports you think are necessary to help people attain and sustain housing?



Step 3

Take an inventory of the services your organization offers and if your organization meets the provider qualifications

Inventory and Crosswalk

- What services does your organization provide?
 - What are the activities or major components of each service?
 - Who are the staff persons that perform these services?
 - Credentials – degrees, years of experience in field, “lived experience”
 - Who provides supervision for the staff?
 - Who do you provide these services for (by Medicaid eligibility requirements/ types in your state)

Inventory and Crosswalk

- Identify the administrative tasks your agency is required to perform, how are you organized and who performs those tasks
- Crosswalk and identify gaps or differences between your organization's service(s), what the state and/or managed care is purchasing and best practice requirements for permanent supportive housing or other services you are providing for persons who are homeless

New Mexico: Community Support Services

- Service Definition: The purpose of Community Support Services is to surround individuals/families with the services and resources necessary to promote recovery, rehabilitation and resiliency. Community support activities address goals specifically in the following areas: independent living; learning; working; socializing and recreation. Community Support Services consist of a variety of interventions, primarily face-to-face and in community locations, that address barriers that impede the development of skills necessary for independent functioning in the community.
- Community Support Services also include assistance with identifying and coordinating services and supports identified in an individual's service plan; supporting an individual and family in crisis situations; and providing individual interventions to develop or enhance an individual's ability to make informed and independent choices.

New Mexico: Community Support Services

Target Population: Individuals having problems accessing services and/or receiving multiple services from a single or multiple providers and/or systems and:

- Individuals needing support in functional living or
- Individuals transitioning from institutional or highly restrictive settings to community-based settings or
- Children at risk of/or experiencing Serious Emotional/Neurobiological/Behavioral Disorders or
- Adults with severe mental illness (SMI) or
- Individuals with Chronic Substance Abuse or
- Individuals with co-occurring disorder (mental illness/substance abuse) and/or dually diagnosed with a primary diagnosis of mental illness

Crosswalk Steps

1. Select Services across the array of services in your State's Medicaid Plan that when combined will best meet the needs of your target population and/ or service you believe you are qualified or best able to provide
2. Fill in top box and far left hand boxes with descriptions from the State Plan
3. Compare the state Plan with best practice SH interventions and needed administrative support
4. The comparison will lead you to your “fit” and to “gaps”
5. Use these “fits” and “gaps” to inform your agency's (or group you are advocating for) plans to increase the use of Medicaid
6. Add action step for each fit or gap with focus on: education, skill building and knowledge acquisition, capacity building, adding staff with required credentials, changing business model, etc.

Crosswalk Exercise

Crosswalk Example

Services Requirements	Services Match to SH Interventions	Gaps/ Changes Needed
<p>1. Targeted Case Management: Case Managers are responsible for assisting individuals in making full use of natural community supports. In addition to all available mental health services which will enable the individual to live in stable healthy and safe life in the community of their choice. This will be accomplished by assessing the individual's needs, developing a personal goal plan with the individual, linking the individual to agreed upon services and ongoing monitoring of these services and supports.</p>		
<p>1. Assuring 24-access to case management services</p> <p>2. Continuous assessment of the individual's needs</p> <p>3. Assisting the individual with the development of personal goals.</p> <p>4. Linking the individual to his or her services</p> <p>5. Monitoring those supports and services for appropriateness and effectiveness</p> <p>6. Advocacy at all levels on behalf of individuals</p>	<p>Targeted Case Management Services are tailored to accommodate the specific tasks associated with engagement, support and linking to community resources to assure an individuals' success in supported housing.</p> <p>Specific Supportive Housing Interventions (three [3] thru six [6]) fall within the scope of TCM when supporting the targeted populations (those with serious mental illness); discussion related to stand alone activities for tenancy and housing choice need further discussion.</p>	<p>Direct treatment Services are not included and cannot be billed as case management services , some direct activities are billable where community resources to achieve this task are not available(XXX Reg.)</p>

Step 4

Learn about the necessary
provider infrastructure

Infrastructure Requirements

- Record-keeping and service documentation
- Staffing and supervision requirements (e.g. Medical Director)
- Hours/after hours availability
- Building / location
- Licensure and/or certification
- Billing and/or certification requirements
- Insurance verification and monitoring
- Quality management and monitoring

Infrastructure Requirements

- There are also flow through and other requirements each agency must be prepared to meet:
 - Accept referrals and assign tasks —see services pathway diagram
 - Be available to landlords and property managers
 - Assure staff have both housing and services competencies and knowledge
 - Negotiate care with other service providers and managed care organization(s)

Infrastructure Tips

- Crosswalk documentation and reporting requirements between what is required as a Medicaid provider and what is required as a housing organization
- Remember: “watchful oversight” and coverage not allowable Medicaid costs
- Monitor for staff’s ability to do “with” not “for” people
- Do a time study to determine looking at service “unit of time” level data if your staff can meet Medicaid business productivity requirements

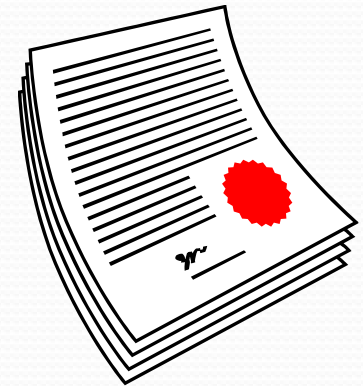


Step 5

Gathering materials to apply

Gathering materials to apply

- Obtain copies of any necessary licensing applications or provider enrollment packets
 - Remember the provider requirements for many services require that your organization be certified by another entity **before** you can apply to be a Medicaid provider
 - Medicaid managed care entities have a separate provider enrollment and credentialing process



New York's Medicaid Provider Application Process for Substance Use Providers

The NY state Medicaid agency, the Department of Health (DoH), requires that SUD programs be certified by the Office of Alcoholism and Substance Abuse Services and **in possession** of an OASAS operating certificate **before** the program may apply for enrollment in the Medicaid program.

New York's Medicaid Provider Application Process for Substance Use Providers

Step 1: Apply for OASAS certification

Step 2: OASAS sends the provider an approval letter, an OASAS operating certificate, a Medicaid provider application package and Medicaid rate info for the service. OASAS also sends a copy of the OASAS operating certificate to the DoH.

Step 3: Providers complete the Medicaid provider enrollment/application package and submit it to the Computer Sciences Corporation (CSC).

Step 4: DoH and CSC review the Medicaid provider enrollment package. Upon approval, the DoH supplies the provider with the appropriate Medicaid billing codes, corresponding payment amounts and effective date.

Step 5: Providers complete the application for the **National Provider Identification (NPI)** number.

Connecting with Medicaid

Option 1

- Become a Medicaid provider

Option 2

- Subcontract

Option 3

- Make connections

Option 2: Subcontracting

Step 1

- Get to know the single state Medicaid agency

Step 2

- Learn about what services are covered
 - Make sure that the service(s) don't have restrictions on subs

Step 3

- Take an inventory of the services your organization offers

Step 4

- Learn about the necessary infrastructure

Step 5

- Research established Medicaid providers and approach them with plan

Step 6

- Negotiate and develop subcontract
 - Understand issues of liability and accountability
 - Audit / compliance issues

Connecting with Medicaid

Option 1

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ACA Medicaid Eligibility Expansion...

- Expanded eligibility does not translate into enrollment
- Housing and homeless advocates can play a major role in facilitating the enrollment and re-enrollment processes



Homeless People & Medicaid - Penetration

- Many participants in homeless programs in the nation were not receiving Medicaid
 - Some not eligible
- As many as 50% of homeless people presumed eligible for Medicaid were not receiving it
- Many homeless people have conditions that would qualify as a disability for Medicaid, but think they are not eligible
- Significant barriers to the application and enrollment process for homeless people – ACA makes improvements to this

Make connections

- Dedicate staff or other resources to facilitating enrollment in Medicaid
 - Some states have grants or free training and technical assistance for community groups interested in helping enroll people in Medicaid
 - Start a SOAR initiative at your organization
- Learn who are the Medicaid providers in your locality and develop relationships with these providers to help facilitate referrals for services
 - Keep in mind “free choice of provider”

Q & A



For More Information

- *How Health Care Reform Strengthens Medicaid's Role in Ending and Preventing Homelessness: Medicaid Eligibility Expansion*
<http://www.tacinc.org/downloads/Medicaid%20Expansion%20homeless%20final.pdf>
- *Assessment of Continuum of Care Progress in Assisting Homeless People to Access Mainstream Resources (HUD)*
<http://www.tacinc.org/downloads/Pubs/Report%20I.pdf>
- *Replicable Best Practices for Accessing Mainstream Resources: A Guide for Continuums of Care (HUD)*
<http://www.tacinc.org/downloads/Pubs/Report%20II.pdf>
- *Strategies for Improving Homeless People's Access to Mainstream Benefits and Services (HUD)*
<http://www.huduser.org/publications/pdf/StrategiesAccessBenefitsServices.pdf>

For More Information

- *Connecting with Medicaid: Strategies and options for providers of services to people who are homeless*
<http://www.tacinc.org/downloads/Connecting%20with%20Medicaid%20final.pdf>
- *Leveraging Medicaid: A Guide to Using Medicaid Financing in Supportive Housing* <http://www.tacinc.org/downloads/Pubs/Medicaid-Final-July10.pdf>
- *A Primer on How to Use Medicaid to Assist Persons Who are Homeless to Access Medical, Behavioral Health and Support Services*
https://www.cms.gov/CommunityServices/downloads/Homeless_Primer.pdf
- *Medicaid: A Primer 2010*
<http://www.kff.org/medicaid/upload/7334-04.pdf>
- *The Role of Medicaid in Improving Access to Care for Homeless People*
<http://www.urban.org/publications/410595.html>

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