National Alliance to
END HOMELESSNESS

Can Medicaid Reform Make a Difference for Homeless Individuals?
Key Considerations for Advocates

As parts of the Affordable Care Act (ACA) are gradually phased in, state leaders are facing complex decisions on issues Congress has left for states to resolve. One of the biggest challenges will be managing major changes in publicly-funded and safety net programs. Meanwhile, ACA implementation creates new opportunities for housing experts to inform state Medicaid programs to benefit more homeless and at-risk individuals. Factors unique to individual states will shape these opportunities and prospects for implementation – for instance, demographics, economic conditions, and leadership on social issues. Further, in political terms, much depends on a state's partnership with the federal government and the state's record of adopting innovations as federal health care policy has evolved over time.

Within homelessness assistance systems, leaders who are knowledgeable about health care programs can identify and navigate the post-ACA environment. First steps would include these activities:

- **Engage with mainstream health care stakeholders.** With expertise on reaching vulnerable people who could achieve housing stability with appropriate services in the community, the homelessness assistance community has a key role to play.
- **Convey the vision of ending homelessness.** Offer credible facts and solutions that might not otherwise be recognized in mainstream approaches to health care delivery.
- **Emphasize that Medicaid home- and community-based services (HCBS) can contribute to successful living situations.** Assuming that housing is secured with funding from programs other than Medicaid, HCBS can increase housing stability, for example, in permanent supportive housing.

Introduction: Medicaid and the ACA

The ACA will expand Medicaid in 2014 to cover an estimated 16 million more people across the nation. This makes Medicaid a primary platform for comprehensive health care reform. State Medicaid programs must enroll millions of low-income U.S. citizens as part of the national objective to cover 32 million uninsured people.[1] On a separate track, the ACA encourages states to "modernize" their Medicaid programs – to deliver services more cost effectively and improve patient-centered care management. In addition, Medicaid operations will have to become more streamlined across states, with uniform benchmark benefits and standard administrative processes.[2]

Focusing on Medicaid as a state matter, this issue brief provides key policy information and perspectives to support engagement by community stakeholders in housing and homelessness assistance. The following pages highlight the most relevant aspects of Medicaid under the ACA.

1. New Mandatory Eligibility for Previously Uncovered Adults
2. Community-Based Services: Options for Expanded Access and System Change
3. Preserving Access and Simplifying Enrollment

Communities can use this information to inform health care strategies in connection with their plans to end chronic homelessness.

1. New Mandatory Eligibility for Previously Uncovered Adults

By 2014, all states must provide standard Medicaid coverage to all adults under age 65 with incomes at or below 133 percent of the federal poverty level.[3] This will extend comprehensive health care coverage, termed "benchmark benefits," to all income-eligible adults who are currently uninsured. States can choose to expand in this way before 2014, and a streamlined federal review process is available to expedite this option. To date, Connecticut, the District of Columbia, and Minnesota have availed themselves of the opportunity. Connecticut and the District of Columbia had previously been covering more adults than required, without using Medicaid funds. They are now able to capture new federal subsidies, freeing up state dollars for other uses.[4]

For states to finance the new Medicaid coverage, federal subsidies will be substantial.

- Coverage of *newly-eligible* individuals will be financed *entirely* by the federal government in the first three years. The proportion of the federal share will decrease by increments in the following three years, but will even out at 90 percent from 2020 forward. A newly-eligible individual is defined as a person who was not eligible under state criteria as of December 2009, or who was eligible but not enrolled due to program caps or waiting lists.
- For *currently-eligible* persons, the federal share of financing continues as effective in 2010 for each state (subject to temporary enhancements enacted as national

economic measures). Eligibility criteria must also continue unchanged, under the "maintenance-of-effort" provisions of the ACA.[5] A currently-eligible person is one who would have met a state's eligibility criteria immediately prior to passage of the ACA in March 2010.

Key considerations:

- States are engaged in planning for 2014, with varying degrees of public input, even as current state budget crises become more urgent. While much of the attention seems to be devoted to the complexities of private health insurance, Medicaid managers in most states are also redesigning public programs based on ACA changes.
- Current state fiscal challenges need not dominate longer-term planning for state Medicaid reform. Compared to the federal commitment, states are facing small extensions of their Medicaid obligations – 1.25 percent more than was projected without the ACA, over 10 years.[6] In fact, the Medicaid reforms improve state health budget forecasts for later years. Advocates can make this point, which is frequently overlooked, when emphasizing Medicaid's role in plans to end homelessness.
- Mainstream consumer advocates will be pressing state leaders for robust and complete Medicaid benefits, especially to ensure access to meaningful mental and behavioral health treatment. Representatives of chronically homeless populations clearly have a stake in this conversation and can add an important voice.
- In 2014, the ACA will begin to reduce the separate subsidies by which Medicaid has compensated hospitals serving a disproportionate number of uninsured and high-needs residents (called "disproportionate share hospital (DSH) payments"). In concept, this shift in payment incentive relates to the coverage expansion as a strategy to reduce high-cost uncompensated care. It is not yet clear what impact the partial loss of DSH funding will really have on safety net systems in communities.

2. Community-Based Services: Options for Expanded Access and System Change

To fully understand the ACA's drive to change Medicaid service delivery, it is important to be aware of the program's history. Medicaid was originally designed with a so-called "institutional bias." This general policy framework favored institutional care to meet intensive or long-term needs of vulnerable groups – the frail elderly and those with developmental disabilities or severe mental illness. Thus, initially, Medicaid paid for few supportive services outside of institutions, leaving a significant gap in access for low-income people with disabilities who need a limited level of help to thrive in the community.

Gradually, restrictive federal rules have been relaxed, allowing states to begin reshaping service delivery with less reliance on institutions and more emphasis on independent living. In Medicaid terms, the vehicle for this change is known as home and community-based services (HCBS). Congress and states have addressed these coverage and service gaps incrementally. Specifically, Congress has offered states more funding to meet individual needs in the community, and granted flexibility for them to invest in HCBS service delivery. Under the ACA, Medicaid continues on this path with additional state options to design non-institutional programs for disabled populations, recognizing their diverse needs and preferences.

To be sure, not all of the new HCBS provisions are particularly designed for chronically homeless people or residents in permanent supportive housing. But if embraced by states, these ACA options would strengthen the infrastructure for all community-based services and supports – with new funding, improved quality and accountability, and more useful data for evaluation. With system change already under way in many states, a number of these opportunities are intended to be active before the 2014 coverage expansion is launched. Implementing guidance from the U.S. Department of Health and Human Services (HHS) is expected in 2011 and 2012.

In the context of ending homelessness, the best-case scenario would be that states aggressively adopt HCBS approaches so as to make supportive housing more sustainable for residents and providers. Specifically, more Medicaid matching funds are available for personal care and attendant services, case management, mental health services, and other supports.[7] These types of supports in the community are critical components of successful outcomes in permanent supportive housing.[8] At the same time, system change promotes integrated systems of care at the community level. Proponents of housing solutions to end chronic homelessness are uniquely able to inform strategies for improving Medicaid HCBS. Specific options include the following.

- *State Plan HCBS.* States can now more flexibly develop and target programs for defined populations based on the services and supports they need to live independently – for example, mental health services, psychosocial supports, and case management. To avoid the alternative of institutionalization, people with incomes of up to 300 percent of monthly Supplemental Security Income (SSI) could be eligible for needs-based HCBS. Otherwise, income eligibility is set at 150 percent of the federal poverty level. This State Plan HCBS provision offers a definite boost to state compliance with the Americans with Disabilities Act (ADA) of 1990. The Supreme Court's *Olmstead v. L.C. & E.W.* (*Olmstead*) decision in 1999 recognized a right for disabled people to have services and supports in the least restrictive setting. Many communities have been slow to find or commit the resources necessary to implement *Olmstead* reforms. Now, states can more easily access federal funding for HCBS with the requirement of having to show measurable system improvements within five years.

- *Medicaid Health Homes*. The ACA encourages states to establish "health homes" to encourage more coordination of services to Medicaid enrollees with high needs. "Health homes" would be a designation for providers that serve specified patient populations and can provide case management; organize interdisciplinary teams; and pursue comprehensive care strategies – potentially incorporating non-Medicaid services and funding streams. Qualified health home designs can be implemented by state plan amendment, with 90 percent federal funding for the first four years. Separately, Medicaid can award planning grants to support development of effective care teams and practices. The ACA provides $25 million to fund the planning grants. The ACA health homes will build on integration approaches already emerging in various public and private systems across the country, but will be more comprehensive.
- *Attendant Services.* A new plan option called "Community First Choice" also expands access to more services in the community. Medicaid will reimburse participating states an additional 6 percent of usual matching funds for personal services and supports of a wide variety, including costs associated with transition to stable housing. States have flexibility in defining delivery models, including consumer-directed arrangements.

Key Considerations:

- The newer HCBS options can support improved coordination and enable a broader scope of services. The most promising Medicaid-supported models would also facilitate timely and seamless access to non-Medicaid services – such as subsidized housing and social services – as well as covered health care. It is not yet clear how far federal guidance will go in promoting the most extensive models. The issue can be addressed at the state level, however, if leaders recognize the connections with relevant housing strategies.
- As Housing First proponents know, community outcomes depend in part on the successful self-activation of willing individuals. Therefore, HCBS programs have to reflect the diversity of needs and care-seeking preferences among various populations needing support to live independently. It will be helpful to reinforce this message in policy conversations.
- Given state fiscal pressures, state policymakers must be persuaded by the cost case for Housing First and HCBS before they will commit budget lines to new Medicaid options. Funding and bureaucratic silos may present a challenge to demonstrating overall savings, as opposed to cost shifting. Advocates for vulnerable populations need to work together on evidence-based solutions, and avoid narrow, program-centric advocacy that will undermine shared goals.
- Whatever their current commitments to HCBS, states ultimately have little choice but to embrace system change. There is strong societal demand for access to services in non-institutional settings, and the *Olmstead* decision makes HCBS a matter of right under the ADA. For Medicaid's part, there is wide consensus that fragmented funding arrangements add unnecessary costs, limit accountability,

and impede effective care delivery. Congressional interest in a new approach is encouraging news for community leaders executing plans to end chronic homelessness.

3. Preserving Access and Simplifying Enrollment

The ACA will change how states operate their Medicaid programs. New federal requirements will lead state administrators to streamline entry and enrollment, establishing certain administrative norms across the states. The intended result is a more user-friendly program for participants and providers.[9] For example:

- States are charged with executing outreach efforts needed to enroll all uninsured residents, including newly eligible populations.
- Maintenance-of-effort provisions preclude states from making changes in enrollment and renewal processes if doing so would reduce access to coverage. This protection is in effect now.
- The ACA creates "presumptive eligibility" processes. Presumptive eligibility allows hospitals to assess and reasonably deem someone Medicaid-eligible at the time and point of service, with reduced financial risk for erroneous decisions.[10] Presumptive eligibility also promotes timely access to appropriate care in the most appropriate, preferred settings. It is considered an effective strategy to reduce unnecessary institutional admissions.

Key Considerations

- For enrollment activities, administrators will likely draw from lessons learned in the recent expansion of the Children's Health Insurance Program (CHIP). CHIP spurred some states to develop more interactive data systems and update their enrollment processes. However, community-based relationships were also found to be important in CHIP enrollment.[11] Stakeholders with expertise in reaching vulnerable adults can make valuable contributions to new Medicaid outreach strategies. Without their informed recommendations, uninsured chronically homeless people are likely to remain in the gaps or fall into new gaps.
- As noted above, the federal funding for the Medicaid expansion is substantial (first at 100 percent, then eventually reduced to 90 percent). States are required to enroll newly eligible people for the mandatory "benchmark" benefits and have good incentive to do so. However, the ACA does not guarantee that this group will have easy access to optional Medicaid benefits which may be more relevant, such as HCBS. Again, advocates for chronically homeless people can support and strengthen mainstream health care advocacy by pressing for state enrollment programs that screen for all available Medicaid services, whether or not funded at ACA rates.
- As Medicaid realigns payment incentives to bring long-term services and supports closer to community-based health care, treatment and referral patterns will change. For chronically homeless people, hospital emergency rooms will

eventually become less attractive and less accommodating for strictly social needs and non-urgent health care. Caregivers and care workers need education and support to manage this transition in the most client-centered manner possible. Further, all stakeholders should have realistic expectations for changes in care-seeking by the neediest and most vulnerable people. System change is a shared responsibility. Advocates for chronically homeless people have an opportunity to lead by introducing new ways to bring housing and health care together for vulnerable consumers.

Conclusion

In addition to making Medicaid the insurer of all adults up to 133 percent of the poverty level, the ACA allows states more flexibility to shape and expand HCBS systems, and offers some additional funding to do so. Depending on state adoption, Medicaid HCBS can contribute to successful housing solutions for chronically homeless people. To the extent that states choose flexible options, leaders focused on ending homelessness are key stakeholders in ACA implementation, and can effectively move a broad agenda forward.

Early Action Steps

While federal and state governments wrestle with decisions necessary to implement the ACA, homelessness advocates should:

- Identify mainstream partners, understand their priorities, and be a voice connecting existing housing solutions with access to health care.
- Talk to partners and community stakeholders about what is already working for chronically homeless people, emphasizing the specific health care services needed for housing stability.
- Enlist interagency councils to carry appropriate messages and promote relevant housing and health solutions in state implementation planning.
- Advocate for state funding of Medicaid HCBS.

At the national level, advocates for homeless people are pressing for Medicaid guidance and regulation to maximize community-based opportunities. The National Alliance to End Homelessness will join these efforts when they are aligned with our existing strategies. In addition, we will offer information, tips and recommendations about state implementation decisions as they might affect local strategies to end homelessness.

For More Information About the ACA

Homelessness and Health Care Reform

- U.S. Interagency Council on Homelessness
  http://www.usich.gov *under Archives, e-newsletter, December 15, 2010*
- Corporation for Supportive Housing
  http://www.csh.org

Mental and Behavioral Health and the ACA

- Substance Abuse and Mental Health Services Administration
  http://www.samhsa.gov/healthreform
- Bazelon Center for Mental Health Law
  http://www.bazelon.org *under Access to Services*

ACA Implementation

- Henry J. Kaiser Family Foundation
  http://healthreform.kff.org/
- National Governors Association
  http://www.nga.org
- National Conference of State Legislatures
  http://www.ncsl.org *under Issues and Research*

Long-Term Services and Supports – Home and Community-Based Services

- Clearinghouse for Home and Community-Based Services
  http://www.hcbs.org
- Center for Health Care Strategies
  http://www.chcs.org

---

[1] Congressional Budget Office, *Letter to House Speaker Nancy Pelosi*, March 2010, appended Table 2.

[2] AcademyHealth, *Reimagining Federal and State Roles for Health Reform Under the Patient Protection and Affordable Care Act*, August 2010.

[3] The FPL is currently set at around $10,800annually for an individual, and $22,000 for a family of four (in all states except Alaska and Hawaii).

[4] Center on Budget and Policy Priorities, *Some Recent Reports Overstate the Effect on State Budgets of the Medicaid Expansion in the Health Reform Law*, October 2010.

[5] AcademyHealth, *Reimagining Federal and State Roles for Health Reform Under the Patient Protection and Affordable Care Act*.

[6] Center on Budget and Policy Priorities, *Some Recent Reports Overstate the Effect on State Budgets of the Medicaid Expansion in the Health Reform Law*. Discussion cites estimates from Congressional Budget Office, which include effects on Children's Health Insurance Program.

[7] National Academy for State Health Policy, *Implementing the Affordable Care Act: New Options for Medicaid Home and Community Based Services*, October 2010.

[8] National Alliance to End Homelessness, *Chronic Homelessness: Policy Solutions*, March 2010.

[9] Kaiser Commission on Medicaid and the Uninsured, *Optimizing Medicaid Enrollment: Perspectives on Strengthening Medicaid's Reach under Health Care Reform*, April 2010.

[10] The Henry J. Kaiser Family Foundation, *Medicaid and Children's Health Insurance Programs: Provisions in the New Health Reform Law,* April 2010.

[11] Kaiser Commission on Medicaid and the Uninsured, *Optimizing Medicaid Enrollment: Perspectives on Strengthening Medicaid's Reach under Health Care Reform*, April 2010.