Can Managed Care Work for Homeless People: Guidance for State Medicaid Programs

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Executive Summary

As managed care becomes the "preferred" mechanism for organizing and delivering health care, homeless people are increasingly included among the enrollees in state Medicaid managed care programs. Their participation in managed care is challenging for several reasons:

- The social circumstances of homeless people are often not compatible with the tightly controlled access to health care that characterizes managed care.
- The health status of many homeless people is markedly inferior to that of traditional managed care enrollees, and is characterized by complex, interrelated conditions, including non-medical factors not usually addressed by managed care entities (MCEs).
- Data on health care utilization, cost and outcomes have not been collected and analyzed for homeless people as a group, undermining the ability of states to effectively integrate them into managed care arrangements.

Homeless people are a special needs population that share:

- identifiable social characteristics (chiefly their lack of housing) which distinguish them as a group and diminish their ability to access health care services; and
- extremely poor health status which threatens their individual functioning, and/or the public health, while at the same time posing significant avoidable public costs for deferred treatment.

Homeless people are not alone in meeting this definition of a special needs population. To assure that the health care needs of all special needs populations are addressed in managed care delivery systems, it is critical that these populations be identified, particularly where Medicaid or other public funding is involved.

This document presents nineteen quality and access issues specific to the special needs of homeless people in a managed care environment. State officials, MCEs, health care providers, advocates and consumers should consider these issues as critical factors as they develop and implement managed care programs for the Medicaid population. For convenience, these critical factors are organized using the framework outlined in KEY APPROACHES TO THE USE OF MANAGED CARE SYSTEMS FOR PERSONS WITH SPECIAL HEALTH CARE NEEDS.

This Health Care Financing Administration (HCFA) draft document recommends some initial steps that states can take in developing a managed health care system that meets the needs of special populations. In doing this, KEY APPROACHES highlights two major themes that are central to the 19 critical factors for homeless people enrolled in managed care and that are addressed in this guide: 1) promoting access to an appropriate range of services; and 2) assuring that payment methods and information systems support quality health care delivery systems.

1. Promoting access to an appropriate range of services

Outreach, education and close monitoring are critical to promote access to services. To address this issue for the homeless population, we are recommending that:

- outreach and education precede enrollment into managed care and be an integral part of marketing and enrollment activities;

- homeless beneficiaries who are auto-assigned enroll in plans with providers who are experienced in serving homeless people;

MCEs enrolling homeless persons create linkages with homeless health care providers offering a wide range of culturally appropriate Medicaid and non-Medicaid services, including case management and sub-acute infirmary care, and that these services be accessible at sites such as soup kitchens, drop-in centers, and shelters, where homeless people feel comfortable and are willing to receive care.

2. Assuring payment methods and information systems to support quality health care delivery systems

Successful quality improvement strategies are at the heart of responsive and appropriate health care systems for special needs populations. However, in order to implement quality improvement strategies and payment methods which reflect the increased cost of providing care to special needs populations (including homeless people), information systems must be able to identify these populations in the system and collect population-specific data. To address this issue, we are recommending that:

- homeless Medicaid beneficiaries be identified early in the outreach and education phase, long before enrollment takes place;
- housing status or homelessness be markers for increased health risk;
- specific quality assurance activities and outcomes measures, focusing on homeless enrollees, be developed in collaboration with advocates and experienced homeless service providers;
- data collected be analyzed on an actuarial basis when the state is moving toward or considering risk-adjusted payment methodologies that reflect the cost and utilization patterns of homeless people.

Preface

Fifteen years ago, most homeless people did not have access to health care for a host of reasons. In answer to this, The Robert Wood Johnson Foundation and Pew Memorial Trust established the National Health Care for the Homeless Demonstration Project. Then, eleven years ago Congress passed the Stewart B. McKinney Homeless Assistance Act, which is the basis of the Health Care for the Homeless Program within the Public Health Service at the Bureau of Primary Health Care. Today, there are 128 federally funded health care for the homeless projects across the country. For over thirteen years, health care for the homeless providers have been learning the ins and outs of delivering health care and social services to homeless people at shelters, soup kitchens, and drop-in centers.

The advent of managed care now poses new challenges for homeless people and their health care providers. However, as new systems for financing and delivering health care develop, it is our responsibility to share our experience and perspective with policy makers, so that homeless men, women, and children will be assured of the comprehensive care that they require. Such is the intent of this document.

The principal author of this document is David Wunsch, a talented policy analyst on the staff of Care for the Homeless. As he has labored to assess how managed care systems might effectively accommodate the harsh realities of homelessness, David has received significant support from our colleagues in homeless health care projects across the nation, and from federal officials at the Bureau of Primary Health Care and at the Health Care Financing Administration. We are grateful for their insight and advice, but the views expressed herein are not necessarily those of anyone other than Care for the Homeless.

David's task has been complicated by the rapid development of managed care and by the variety of arrangements from state to state. We view this document as a first step in what will necessarily be a long process of policy development as managed care begins to reach homeless people and other populations with special health care needs. We welcome your involvement, and we solicit your comments on this document.

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Undoubtedly our faithful collaborators, John Lozier, Executive Director of the National Health Care for the Homeless Council, and Pat Post, the Council's Communications Manager, deserve a special round of accolades. They have been with us every step of the way. Numerous others have made significant contributions, in particular those who served on a committee which oversaw the elaboration of this document, as well as the participants of the focus group in St. Louis, MO. These individuals include Bob Taube, Scott Pinegar, Jim O'Connell, Liz Forer, Sig Olson, Heidi R. Nelson, Leigh Thurmond, Sally McCarthy, Eve Picower, Laura Gillis, Karen Holman, Richard K. Gram, Linda M. Dziobek, Kathy Goldstein, and Kim Tierney.

A special thanks is due to all of our colleagues at Care for the Homeless. Amongst other assignments, Bobby Watts has shared his expertise on managed care issues and its implications for homeless men, women and children. Ellie Tinto, our newest colleague, has both edited the document and contributed her valuable insights. And last, but not least, our thanks to Zipporah Portugal who labored on the format and design of the document.

Furthermore, Susan Moscou, a nurse practitioner on the Montefiore Family Health Center team of Care for the Homeless, reviewed this document through the eyes of a provider.

Most of all, we are grateful for all the staff of homeless care projects who serve homeless men, women, and children.

David Wunsch, *Policy Analyst*
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Introduction

This document provides a set of critical factors and recommendations for you, state administrators, to consider when developing and implementing Medicaid managed care programs (voluntary and/or mandatory) which include homeless people. We hope that our recommendations will assist you, as well as your contracted providers, to develop, implement, and monitor delivery systems that allow homeless Medicaid enrollees to receive the care they need.

As you expand your Medicaid managed care program to include homeless people, you will face unique challenges. To begin with, homeless men, women and children generally have little or no experience accessing health care in a managed care setting. Even without "gatekeepers," "prior authorizations," and "preferred providers," homeless people regularly encounter significant access-to-care barriers from mainstream medical providers. Managed care offers the promise of a seamless, integrated system of health care for all Medicaid beneficiaries. At the same time, most fully and partially capitated systems are imbued with strong economic incentives to underserve vulnerable populations. Unfortunately, these financial incentives can disproportionately undermine access to care for populations with complex social and medical needs, such as homeless people.

In general, homeless people are transient and move in and out of homelessness, impeding integration into the systems of care created by Managed Care Entities (MCEs) to serve an essentially stable clientele. For a homeless family or single individual, a shelter stay may last for a day or a week, although a stay of up to a year or more is not uncommon. After leaving the shelter system, homeless people may live doubled-up, on the street, or in an institutional setting before finally settling into permanent housing. A health care delivery and financing system that serves people living in these conditions must promote maximum flexibility, accessability and choice. Health care and enabling services are most effectively delivered at sites where homeless people congregate and feel comfortable about interacting with medical staff. Appropriate sites are the shelters, soup kitchens and drop-in centers where homeless people go to seek life’s basic necessities such as food, clothing, and a place to sleep.

Whether enrollment in an MCE occurs before or after someone becomes homeless, it is likely s/he will be unable to utilize the services the MCE is being paid to provide until a stable residence is found. For example, homeless Medicaid beneficiaries may end up in shelters that are far from their previous address, rendering their primary care provider, as well as the MCE’s larger network of care, inaccessible. Moreover, during the time they are experiencing homelessness, managed care enrollees are likely to have problems filling prescriptions and accessing specialized care because they are not able to negotiate the appointment, referral and authorization systems used by most MCEs. Homeless people often do not have money for even minimal co-payments and other user fees, nor can they pay for transportation,

regularly receive mail, or be reached by phone. Such access barriers are particularly challenging for homeless people because they suffer from a range of serious illnesses, including mental illness, HIV/AIDS, and hypertension, at higher rates than the domiciled population. At the same time, these access barriers eventually lead to an increased use of emergency rooms and inpatient care, diminishing the cost savings states hope to achieve through managed care enrollment.

The remainder of this document provides guidance for preventing many of the access and quality challenges described above. The critical factors and recommended approaches have been organized into six sections following the framework set out in the draft Health Care Financing Administration (HCFA) document titled: *KEY APPROACHES TO THE USE OF MANAGED CARE SYSTEMS FOR PERSONS WITH SPECIAL HEALTH CARE NEEDS.* The six sections are as follows:

1. The Environment
2. Purchasing Strategies
3. Access and Quality
4. Evaluation and Reporting
5. Benefits and the Delivery System
6. Finance

Each of the six sections of the guide begins with a brief introduction that sets the stage for the critical factors and recommended approaches. The critical factors, set off in bold, small caps, are expanded upon in the recommended approaches that follow. These recommended approaches are for you to consider in developing and implementing Medicaid managed care programs which include homeless people. Finally, the italicized text adds additional clarification, examples and/or rationale to support the recommendations.

1. The Environment

Stakeholder involvement in the development of a state's Medicaid managed care program should begin early and be formally incorporated into planning, implementation and monitoring processes. In some states, institutionalized entities and processes such as ombudsmen programs and advisory councils already exist. In other states, they need to be created to encourage on-going and meaningful participation by key stakeholders. It is important that collective decisions made by such bodies be respected and upheld by the public officials who originally empowered them.

Experience in many states has demonstrated that early and on-going involvement by stakeholders can help facilitate the implementation process. Stakeholders include those who can speak to the needs of homeless people, including homeless people themselves, advocacy groups such as local Coalitions for the Homeless and legal services corporations, homeless health care and social service providers, as well as public agencies. Because homeless populations are heterogeneous and vary both among and within states, stakeholders can help you and local authorities define the characteristics and needs of a specific homeless population.

Critical Factor:

Key stakeholder groups should be formally involved in planning, executing and monitoring state Medicaid managed care programs.

Recommended Approach:

- Seek understanding and input from homeless consumers, advocacy groups, and homeless health care and social service providers when developing, implementing, and monitoring Medicaid managed care programs.

It is often difficult to get input from homeless consumers. To facilitate the involvement of this group of stakeholders, focus groups, surveys, and consumer-oriented advisory committees are alternative methods of getting input.

Critical Factor:

Key stakeholder groups should assist the state in defining and identifying the homeless population.

Recommended Approach:

- Use the following definition of "homeless person" when specifying "special needs populations":
  A homeless person is someone who lacks a fixed, regular and adequate night-time residence and/or a person who has a primary residence that is:
- a supervised, publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, shelters, and transitional housing for the mentally ill and those undergoing addictions treatment); *OR*

- a public or private place not designed for, or ordinarily used as a regular sleeping accommodation for human beings.

As stakeholder groups seek to develop a common definition that differentiates a homeless individual from someone considered housed, the circumstances which force individuals onto the street need to be given primary consideration. For example:

1. overcrowded living conditions, often in situations where individuals and families are forced to double or triple-up with friends or relatives,
2. destructive and abusive home environments, places where homeless youth cannot return because they are not wanted,
3. domestic violence, and
4. other reasons, which include mental illness, addiction disorders, loss of income, and unemployment.

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2. Purchasing Strategy

States face a considerable challenge when purchasing value-based, quality-focused health care for the homeless population. Not only do the access-to-care challenges described earlier make managed care rules difficult, if not impossible, for homeless people to follow, but unknown cost and utilization patterns for this population also complicate the tasks of rate-setting and quality oversight.

Although extensive data are not readily available, existing data suggest that homeless people cost more to serve because of the complexity of their health care needs. Capitated reimbursement arrangements often used in managed care frequently contain strong incentives to underserve this population. Therefore, monitoring under-utilization of all health care services, not just over- utilization of select ones, such as emergency rooms, is of primary importance for homeless enrollees.

States planning to move special needs populations (including homeless people) into managed care need not only consider the impact on enrollees, but also the best care model and the data needs for developing responsive quality assurance programs and value-based purchasing strategies. Where limited data are available for these populations, states may wish to delay moving the population into full-risk arrangements in order to collect the necessary data for payment methodology design and testing.

Transitioning special needs populations through a Primary Care Case Management (PCCM) program, instead of enrolling them directly in more complex MCEs, is an option for states. Such an approach will give you the opportunity to collect data on cost and utilization patterns, and will give homeless enrollees the opportunity to become accustomed to managed care systems, but in a less complex environment.

Critical Factor:

A managed care system for homeless people promotes flexibility and choice.

Recommended Approach:

- Consider a range of financing and service delivery options when enrolling homeless Medicaid beneficiaries in managed care. We recommend that you promote accountability among contracted MCEs through value-based purchasing strategies.

Using a Primary Care Case Management (PCCM) model for homeless people for two years before moving them into a fully-capitated model offers you the opportunity to evaluate the experiences of homeless Medicaid recipients in managed care plans, to collect data needed for monitoring access and quality of care, and to develop reimbursement methods.

Giving homeless people free access to certain frequently needed services and drugs not included in the benefit package or in MCE formularies during the initial start-up of a Medicaid managed care program, would assure the continuity of care necessary for those with behavioral problems, addiction disorders, and other serious illnesses such as HIV/AIDS. Such a policy would also help you promote important public health goals.

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3. Access and Quality

Promoting access to quality health care begins with education and outreach activities prior to enrollment and extends to monitoring on-going utilization of services. (Although the concepts of access and quality are inextricably linked, quality assurance activities are also addressed in the "Evaluation and Monitoring" section and will only be given cursory treatment here.)

First, a key element for making managed care work for homeless people is an appropriately designed enrollment process. The enrollment experience affects everything else, including an appropriate choice of provider, continuity of care, consumer satisfaction, auto-assignment rates, and positive health outcomes. Auto-assignment is particularly challenging because homeless people often do not receive written communications or calls since they usually do not have a permanent address or phone. For this reason education and outreach, both key components of the enrollment process, should begin long before a homeless Medicaid beneficiary decides or is obligated to join an MCE.

To successfully complete the enrollment process, a first priority is to develop a strategy to identify homeless Medicaid beneficiaries. Identification of an individual's housing status is critical and can be facilitated if:

1. homelessness is a check-off box/data field on the state's Medicaid application, *and if*
2. a social and medical needs assessment, including current housing status, is done early in the enrollment process.

Next, you need to scrutinize the enrollment process, particularly the auto-assignment algorithm, and determine whether the special enrollment needs of homeless people are addressed. Finally, once enrollment takes place, states need to determine whether homeless enrollees are actually accessing services from the contracted provider, under what circumstances care is sought from non-network providers, and whether a standing disenrollment option would be appropriate.

Critical Factor:
Outreach and education activities take place both before and after a homeless beneficiary is enrolled in an MCE.
Recommended Approaches:

- Work with MCEs, enrollment brokers, homeless stakeholder groups, public agencies, and other existing community resources to design outreach strategies and educational materials appropriate for the homeless population.
- Ensure that homeless managed care enrollees have received adequate information about the complaint, grievance, and appeals processes.
- Through regular monitoring, identify factors to consider when verifying that the complaint, grievance, and appeals processes are working for this population.

Appropriate outreach activities and educational materials are critical to reaching this population. For example, the lack of a permanent address and phone make outreach and monitoring a challenge. Therefore, it is important to involve key staff of community based organizations which serve homeless people at locations where they congregate and feel comfortable about interacting with staff. These sites include shelters, drop-in centers, soup kitchens, and street locations when appropriate. At a minimum, the educational materials should be distributed to these organizations, as well as to participating MCEs and their provider networks.
The educational materials should describe eligibility requirements and provide adequate information about the complaint, grievance and appeals processes, any exemptions and disenrollment options, homeless shelter sites and locations of other homeless service providers, as well as referral sources where additional information about the state's Medicaid managed care program can be found. Finally, a culturally competent contact person can be identified to help providers and eligible beneficiaries understand the materials and their intended use.

Critical Factor:

Special considerations are needed for the enrollment and disenrollment processes and ongoing care delivery to homeless Medicaid beneficiaries.
Recommended Approaches:

- Collaborate with MCEs and homeless stakeholder groups to identify homeless individuals and families prior to initiating the enrollment process.
- Request information on housing status and homelessness in the Medicaid application and in other instruments used by states and localities.
- Consider homelessness as a basis for exemption from either mandatory enrollment or auto-assignment, or both.
- Allow homeless clients to access care without authorization from the PCP until initial provider/patient contact is made following enrollment into managed care.

Use confidential follow-up and/or face-to-face contact by the enrollment agent and/or outreach worker, particularly in the case of

known homeless individuals who do not respond to initial mailings and phone calls. MCEs can make the following 3 types of follow-ups when a new or continuing enrollee fails to appear for an appointment or is lost to follow-up:

1. *by telephone;*
2. *by mail;*
3. *through face-to-face contact.*

These steps allow MCEs to identify homeless enrollees not connected with their primary care provider. Creative approaches for reaching homeless people are important to consider because traditional forms of communication will often prove ineffective. If the enrollee still cannot be reached and/or is determined to be homeless, the contracted provider should inform the local or state Medicaid authority. A simplified disenrollment process, preferably instituted by phone, will increase continuity of care and give homeless enrollees flexibility to make choices.

Critical Factor:

An initial health assessment conducted prior to the effective enrollment date is one way to determine homelessness.

Recommended Approaches:

- Participating MCEs and/or enrollment brokers can conduct a social/health assessment at the time of initial contact with an enrollee. Use the assessment prior to effective enrollment to identify enrollees with special health risks, including homelessness.
- Once enrolled, update housing status and history of homelessness every six months as part of an on-going assessment.

Findings from the health and social needs assessment can be used to help homeless Medicaid beneficiaries choose an MCE with a provider network that meets their special needs.

Critical Factor:

Monitoring of marketing and enrollment practices helps homeless Medicaid beneficiaries to enroll in a plan that meets their needs.

Recommended Approaches:

- Continuous monitoring of marketing and enrollment practices, including the number of homeless individuals who are auto-assigned to an MCE, as well as individuals who switch MCEs during the window before lock-in begins, is important.
- When only small numbers of homeless enrollees can be identified in a certain geographic area, use research techniques, focus groups, or other means, to gather needed data.

You can work with the enrollment broker, homeless stakeholder groups, and/or MCEs to examine whether marketing and enrollment practices address access barriers faced by homeless people. Barriers include, but are not limited to:

1. lack of a permanent address or telephone number, i.e. difficulty in communicating with clients and informing them of enrollment requirements and enrollment/disenrollment procedures,
2. frequent relocation within the shelter system, and
3. difficulty in understanding communications from the MCE or enrollment broker.

Critical Factor:

Auto-assignment may undermine continuity of care for homeless enrollees.

Recommended Approaches:

- Ensure that homeless enrollees can access experienced homeless health care providers in-network.
- When a homeless person fails to choose a plan during the enrollment process, attempt to identify the usual source of care and then assign the beneficiary to an MCE that includes this provider in its network.
- Do not auto-assign before it has been determined that the homeless Medicaid beneficiaries will have an appropriate source of care.

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4. Evaluation and Reporting

States are currently emphasizing purchasing strategies that give value for the dollar. By identifying key quality indicators and data collection processes, you can accurately capture the experiences of homeless people enrolled in managed care. Meaningful indicators and processes can be developed in consultation with experienced homeless health care providers who are familiar with community and population-specific standards. However, after determining how homeless Medicaid beneficiaries will be identified, states and MCEs can compare outcomes of their homeless enrollees to those of members who are housed.

Critical Factor:

Identify homeless status and track utilization and cost experience for this population in Medicaid managed care databases.

Recommended Approaches:

- Design specific strategies to identify homeless Medicaid beneficiaries.
- Collect and analyze quality assurance data specific to homeless populations.

States can provide guidance to participating MCEs on how to identify homeless people among their members. None of the suggestions below is sufficient without testing various methods to identify homeless people. Two suggested methods are:

1. Establish mechanisms to identify homeless enrollees in collaboration with homeless service providers in the MCE's service area.
2. Enter shelter addresses into state/MCE information systems that can be matched with the address beneficiaries give at the time of enrollment.

When formerly homeless people transition into permanent housing, data can continue to be collected from them so that a comparison of service utilization and costs can be made during and after the period of homelessness. In some states, the homeless population may need to be over-sampled to ensure that their experience is adequately represented in the findings.

These suggested strategies can be built into the medical record audits already conducted by states and will assist states and localities to establish a baseline of information for services delivered to homeless people.

Critical factor:

Meaningful quality assurance activities and outcome measures are needed for the homeless population.

Recommended Approaches:

- Use quality assurance activities and outcome measures that reflect the experiences and needs of homeless people.
- Choose outcome measures through a collaborative effort with participating MCEs, consumers and their advocates, and homeless service providers.

Measuring overall satisfaction with care, service utilization, or health outcomes of the general Medicaid population, without focusing specifically on homeless people and the services they depend on, will not provide the findings necessary for on-going quality improvement. A number of outcome measures can enable assessment of services delivered to homeless people in managed care. To begin with, states can monitor how homeless people fare during the marketing and enrollment process, particularly if this population is subject to auto-assignment. Other elements data systems could be designed to monitor include underutilization of service and unauthorized out-of-network utilization. Client/provider satisfaction surveys are necessary but insufficient to address quality measurement; other evaluation tools should be used as well, including a comparison of encounter data with best practice protocols.

Monitoring services essential to homeless people, such as case management, addictions treatment, and behavioral health care is necessary. Documenting the lag-time between enrollment and initial contact with a beneficiary's managed care provider is also important.

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5. Benefits and the Delivery System

Homeless enrollees need a service delivery system and benefits package that is responsive to their diverse medical and social service needs. To begin with, the mainstream medical system imposes a series of well-documented barriers to homeless people that limit access to care. In light of this, it is important to construct a *managed*

health care system that does not replicate the same, or create new, barriers endemic to the fee-for-service system.

Homeless enrollees will be protected if they are enrolled in plans with network providers experienced in delivering culturally appropriate services at locations that are accessible to homeless people, such as soup kitchens, drop-in centers, community based clinics, shelters, and mobile van sites. Monitoring the strength of an MCE's network, and determining levels of provider expertise can be accomplished through oversight activities. Moreover, states may decide that a case manager is most appropriate at the center of service delivery models for homeless people. However, the principal function of a case manager should be to ensure that care is accessed in a timely and appropriate manner, not to act as a "gatekeeper" and restrict access to services. Finally, by strongly encouraging linkages between MCEs and homeless health care providers, the range of issues discussed above can be addressed, resulting in increased access to needed services for homeless enrollees.

Critical Factor:

Demonstrated experience and expertise in serving homeless people is essential for MCEs.

Recommended Approach:

- Determine whether an MCE has an appropriate range and level of experience/expertise in providing clinical and support services to homeless people.

To determine the expertise/experience of a provider network, you can ask MCEs to report on capacity for outreach, documented experience serving the homeless population, and specialized training.

Critical Factor:

Linkages between MCEs and homeless health care providers strengthen provider capacity and cultural competency.

Recommended Approach:

- Identify corrective actions to be taken when MCE provider networks do not have the capacity and/or experience and expertise to serve the homeless people they intend to enroll.

Corrective actions to consider include recommending linkages with homeless health care providers and/or providing a standing referral/assignment to an out-of- network provider with the appropriate technical expertise and experience. Whichever actions adopted would be explained to homeless enrollees at the time of enrollment into an MCE.

Critical Factor:

Respite/infirmary care facilities where homeless people can recover from serious illness are a humane and cost efficient alternative to hospitalization.

Recommended Approach:

- MCEs can purchase and provide respite/infirmary care services that are necessary for the safe and thoughtful treatment of Medicaid beneficiaries who are homeless.

Minimizing length of stay at costly acute care facilities for medical and behavioral health is an important strategy that MCEs can use to contain overall health care expenditures for homeless enrollees. If MCEs recognize that early discharge poses a particular risk to homeless enrollees, it becomes evident that a well-supported place in which to continue their recovery is needed. Where hospital diversion is a priority, homelessness can be taken into account in clinical decision-making and discharge planning. Service models including safe, recuperative medical and nursing care for homeless persons, with assistance in overcoming homelessness, need to be supported where they exist and developed where they do not.

Critical Factor:

A comprehensive service delivery model helps to coordinate services and support for homeless individuals.

Recommended Approach:

- Adopt a coordinated and continuous service delivery system for homeless enrollees.

A comprehensive service delivery model involves the following:

1. *development of an individual care plan;*

2. *on-going contact between the enrollee and his or her primary care provider;*

3. *timely and coordinated access to medically necessary services;*

4. *linkages to other service organizations involved in the care of the enrollee;*

5. *on-site provision of services in adult and family shelters, soup kitchens, drop-in centers, and respite/infirmary care facilities where appropriate hours of operation are maintained and flexible appointment systems are in place;*

6. *access to experienced primary care and specialty providers;*

7. *clinical protocols appropriate for homeless people when choosing among treatment and medication options;*

8. development of inpatient discharge protocols which recognize the needs of the homeless enrollees.

Critical Factor:

The use of case management is an integral part of a comprehensive service delivery model.

Recommended Approach:

- Define the case manager as an advocate for homeless enrollees who:
- assists homeless clients in accessing inpatient specialty care and other services that may require hospitalization, and
- encourages clients to seek out services at sites that provide the necessary level of care.

Case management services are best coordinated at the places where homeless people congregate and feel comfortable about receiving care, such as soup kitchens, shelters, and drop-in centers. The effectiveness of case management services are limited if coordinated at an MCE's central office.

To facilitate the work of case managers and to help maintain stable enrollment, you can limit the use of re-authorizations required by many MCEs and service providers, thereby increasing access to needed services for homeless enrollees.

Critical Factor:

Linkages with non-Medicaid support services enhance access to care and improve health outcomes.

Recommended Approach:

- Include in MCE contracts services (beyond the standard benefit package, if necessary) of particular benefit to homeless people. Principal among these are behavioral health care and addictions treatment.

You can encourage or require MCEs to develop linkage agreements with homeless service providers to facilitate the delivery of non-Medicaid medical and social services, as well as those included in the standard Medicaid benefit package. Compensation can be made to network providers to cover case management and social services, including behavioral health care and addictions treatment.

Some of the services homeless people need for their health care to be effective include, but are not limited to, food and clothing, housing placement, funds for transportation, employment training, and dental care.

Critical Factor:

The transient and unstable lives of homeless people influence the design of information systems.

Recommended Approach:

- Encourage MCEs to use information systems that make medical history and treatment information available to the greatest degree possible at the various sites where homeless enrollees are often seen for care (e.g., soup kitchens, drop-in centers, shelters, and respite/infirmary care facilities) without compromising patient confidentiality.

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6. Finance

One of the most pressing issues states face right now is choosing the most appropriate reimbursement methodologies for special populations for whom little reliable data exist. For homeless enrollees the situation is even more challenging; cost and utilization data for this population has been collected in only a few instances. In the absence of reliable data, unfounded assumptions about "costly, noncompliant" homeless enrollees who "inappropriately access care in the most expensive settings" are perpetuated. In this environment, it is difficult to enroll homeless people in a plan that can best meet their needs and for that plan to anticipate a reasonable rate of reimbursement sufficient to cover costs.

We recommend that you choose from a wide range of financing options when choosing a payment methodology to compensate MCEs that care for homeless Medicaid enrollees. If the eventual goal of state-managed health care systems is a health-based (i.e., risk adjusted by health or social status) reimbursement methodology that fairly compensates efficiently-run plans, collecting needed data and developing risk adjustment formulas is a key challenge to be addressed. If this or other strategies are chosen, homeless health care providers would be pleased to work with you in developing payment methodologies.

Critical Factor:

Payment methodologies that reflect the cost and utilization patterns of homeless people are essential to ensuring efficiently run MCEs and quality health care.

Recommended Approach:

- Ensure that reimbursement methods do not put MCEs and other providers at undue financial risk for caring for homeless people. Reimbursement methods that contain incentives for providing quality care for homeless enrollees are encouraged.

Consideration of a wide range of financial incentives and disincentives is recommended. As already suggested, you may need to collect additional data on special needs populations before risk-adjusted reimbursement rates and/or other incentives can be developed. States considering the development of health-based risk adjusted capitation rates for future use can study how homelessness could be

factored into the methodology. It might be appropriate, particularly if homeless people in your state are few as compared to other special needs populations, to consider this population, or the condition of homelessness, as part of a larger cohort for which adjustments are made.

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