

Searching for the Right Fit: Homelessness and Medicaid Managed Care

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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 serve them through managed care arrangements.

Homeless people are a special needs population that requires additional consideration when designing managed care systems for Medicaid beneficiaries. Homeless men, women, and children are defined as a special needs population because they 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.

Once state officials, MCEs, health care providers, advocates and consumers understand the impact managed care programs are having on special needs populations (including homeless people), strategies should be devised to overcome the multiple barriers these Medicaid beneficiaries face. Strategies should work to:

1. protect the rights of homeless enrollees;
2. promote access to an appropriate range of services; and
3. improve quality of care through responsive payment methodologies and information systems.

To develop a managed care program that will achieve the three goals outlined above, several critical issues should be kept at the fore. For

one, homeless Medicaid beneficiaries should be identified early on in the outreach and education phase, long before enrollment takes place. Also, outreach and education should precede enrollment into managed care and should be an integral part of marketing and enrollment activities. If an enrollee fails to choose a plan, default enrollment should be closely monitored and should only occur with plans offering providers experienced in serving homeless people. Moreover, all plans that enroll homeless persons should create linkages with homeless health care providers which offer a wide range of culturally appropriate Medicaid and non-Medicaid services, including case management and sub-acute infirmity care. Finally, these services should be accessible at sites such as soup kitchens, drop-in centers, and shelters, where homeless people feel comfortable and are willing to receive care.

Other critical issues to consider include quality improvement and risk-adjusted payment methodologies. Successful quality improvement strategies are at the heart of responsive and appropriate health care systems for special needs populations. Unstable housing status should be a marker for increased health risk that becomes part of both a plan's information system, as well as the state's enrollment record. Specific quality assurance activities and outcome measures, focusing on homeless enrollees, should then be developed in collaboration with advocates and experienced homeless service providers. After data is collected and analyzed on an actuarial basis, states can move toward risk-adjusted payment methodologies that reflect the cost and utilization patterns of homeless people. States should not purchase services using full-risk capitated payments until methodologies have been developed and necessary data is available.

Preface

Fifteen years ago, most homeless people did not have access to health care for a host of reasons. In response 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 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. Many advocates and service providers, including the staff of Care for the Homeless, believe that homeless people should be exempt from mandatory enrollment. 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 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 input from our colleagues in homeless health care 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, advice and financial support, 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.

Susan L. Neibacher, *Executive Director*
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David Wunsch, *Policy Analyst*

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Introduction

This document provides a set of principles and illustrative approaches for states to follow when enrolling homeless Medicaid beneficiaries in managed care plans on a voluntary and/or mandatory basis. We hope that our recommendations will assist states, as well as their contracted providers, to develop, implement, and monitor delivery systems and financing arrangements that will allow homeless Medicaid recipients to receive the care they need.

As states move to expand the scope of the Medicaid population enrolled in managed care, homeless people present a unique challenge. Although managed care offers the promise of a seamless, integrated health care system for all Medicaid beneficiaries, homeless men, women and children generally have little or no experience accessing health care in a managed care setting. At the same time, most fully and partially capitated systems are imbued with strong economic incentives to underserve vulnerable populations. These incentives can compromise access to needed services for populations with complex social and medical needs, such as homeless people.

This document addresses the concerns described above and recommends clear options to overcome the access-to-care barriers homeless people face. This "primer" is designed to meet the needs of readers with all levels of knowledge about homeless people, the health conditions that most impact them, and Medicaid managed care programs. Following an overview of all of these issues, six principles and illustrative approaches are presented. The principles should be seen as benchmarks: minimum requirements that should be in place if homeless people are to enjoy access to care within managed care systems. The illustrative approaches which follow each principle are concrete examples of how managed care systems can be made responsive to homeless people. Rather than limiting your options, the illustrative approaches should stimulate creative thinking toward resolving the access barriers described in the primer.

Part 1: Homeless People and Managed Care

Managed Care 101

Managed care is a new and challenging concept for homeless Medicaid beneficiaries. In theory, managed care aims to modify provider and consumer behavior through the use of financial incentives and disincentives to favor early, less expensive preventive care. To achieve this goal, managed care entities (MCEs) are allotted a fixed payment per member, per month to finance all necessary health services provided to enrollees in the health plan.

Under Medicaid managed care, MCEs must guarantee a minimum set of standard benefits to all enrollees. To realize a profit or break even, MCEs must therefore "manage" the care of their enrollees; i.e., provide the most cost-effective care possible. To manage utilization of health care services and to determine the appropriate level of care a patient needs, MCEs employ a triage system, within statutory limits of a state's Medicaid program. No procedure will be conducted, no service provided, without authorization from a "gatekeeper". The gatekeeper decides whether care is actually needed and how services should be delivered and by whom.

To succeed over time, MCEs presuppose that at any given moment there will be more healthy enrollees in a plan than unhealthy ones and that enrollment will remain fairly stable. If these conditions are met, the hope is that increased investment in preventive and primary care services will result over the long term in healthier populations and correspondingly lower health care costs. However, there are those who believe it is also the case that promoting preventive health care practices, like regular check-ups, periodic mammograms, screenings and testing for infectious diseases, etc. also leads to the discovery of expensive illnesses that would have possibly cost less if left alone. This is not to suggest that a health care system that fails to promote preventive practices is acceptable.

Medicaid beneficiaries are usually enrolled in a specific plan for a shorter duration than commercial enrollees. This being the case, long-term, cost effective preventive practices often do not result in financial gains for MCEs. A preventive strategy that reaches sick individuals can

increase significantly the short-term costs of treating undiscovered conditions. For this reason, fiscal incentives may keep the "prevention imperative" from being translated into practice. Instead of preventive practices, MCEs and their participating providers across the country have decreased utilization of services by creating multiple access barriers to care (such as gatekeepers, inexperienced providers, cumbersome referral practices, and copayments) that many vulnerable populations, such as homeless people, cannot overcome.

Although barriers to care exist and present considerable access challenges to homeless people, Medicaid managed care promises a medical home for even the poorest of Americans. In contrast to years past, states now intend for Medicaid beneficiaries to have access to the same doctors who see commercial and Medicare patients. This, in itself, is a guarantor of quality, or so the argument goes. Medicaid mills are no more and a visit to the hospital emergency room can be avoided with a simple phone call. Moreover, every beneficiary can have her "own personal doctor", as advertisements in state after state promise. However, for hundreds of thousands of homeless Medicaid beneficiaries, this new system is intimidating. To create a Medicaid managed care system that works for homeless people, policy makers, MCEs, and health care providers must first understand who homeless people are and how their health care and social service needs are unique.

What characteristics do homeless people share?

Typically most people know the homeless population as those individuals who are visible on the streets and in the parks and subways. In reality, many more hide far from, or are invisible to, the public's eye. Estimates of the number of homeless people on any one day in the United States range from less than 200,000 to over two million. These disparate counts reflect varying definitions of "homeless" and different methods of enumeration. Although the make-up of the homeless population has shifted throughout history, today it includes single men and women of all ages, from all racial and ethnic backgrounds. Youth constitute a greater proportion of the homeless population than ever before, and homeless families are the fastest growing group across the country. No longer found only on skid rows

in large cities, homeless people are now dispersed among cities and towns across the country, living in parks, on the streets, in shelters, rescue missions, welfare hotels, abandoned buildings and cars, and doubled or tripled-up in substandard housing.

In spite of characteristics that divide the homeless population into subgroups, their shared commonalities should be noted. For example, minorities are disproportionately represented among homeless men, women, and children, and studies indicate that homeless people's lives are chaotic long before they become homeless. One study in New York City indicated that 22 percent of homeless single adults had grown up in foster care, institutions, or group homes; 25 percent had run away from home; and a significant number had been physically or sexually abused as children. Among families, pregnancy is a significant factor which can lead to becoming homeless: 35 percent of women seeking shelter were pregnant, while 26 percent had given birth in the past year. These statistics argue powerfully that the causes and the cures of homelessness are far from simple.

Regardless of age, race or family status, homelessness is a condition which both causes and exacerbates illnesses for all people. Homeless men, women and children are exposed to the elements, often malnourished, and frequently the victims of violent attack. This harsh existence is clinically manifest in the large number of treatment encounters homeless people have for lacerations, abrasions, and fractures. Many homeless people are substance abusers and at high risk of HIV infection and Hepatitis A, B, and C because they share needles and engage in unprotected sexual activity. Other ailments commonly experienced by homeless people include upper respiratory infections and skin conditions. Chronic health disorders such as hypertension, diabetes, gastrointestinal disorders, peripheral vascular disease, poor dental health, and neurological disorders, more often progress to acute conditions in homeless people. Additionally, there is widespread agreement that mental health problems both lead to and are exacerbated by homelessness; estimates of the proportion of the single adult homeless population suffering from mental health problems hover around 30 percent.

In the crowded, poorly ventilated spaces where many homeless people are sheltered, airborne pathogens, such as those that cause tuberculosis, spread easily. Chronic conditions such as asthma and hypertension are made more acute by the stresses of homelessness. While pregnancy is not a disease, homeless women are at high risk for medical complications associated with pregnancy. Those homeless people who live on the streets and in abandoned buildings have no access to running water, making it impossible for them to bathe regularly, brush their teeth, or wash their clothes. Strains and sprains are often caused by the heavy loads homeless people carry for long periods of time.

Access to Care Problems Among Homeless People

Homelessness not only makes people sicker, it also limits access to the very health care services they need to get well, thereby frequently prolonging the episode of homelessness. Access to care is limited by the unavailability of phones, displacement from the neighborhood of origin, and the need to have life's basic necessities such as food, shelter and clothing met before seeking health care and social services. Homeless people are transient, frequently moving from shelter to shelter, or from a cramped dwelling belonging to someone else, to the street, a park, or under a freeway. A life full of constant, often brutal, transitions impedes long-term relationships with health care providers, if a relationship is possible at all. Having been the victim of repeated failures of the social service system, including educational, penal, mental health, and health care institutions, both prior to and during their homelessness, homeless clients are often reluctant to seek or accept care in large institutions. In fact, many homeless people actively shun health care providers because they are either fearful or skeptical. Health professionals may take medical histories and ask questions, the answers to which may be difficult or painful to recall. Some homeless people fear that health care professionals will be judgmental or even punitive, and some mentally ill people avoid all close contact as part of their illness.

Few homeless people have health insurance, and those that do generally depend on Medicaid. In states where homeless people qualify for Medicaid or other indigent health care programs, lack of

documentation can prove a barrier to meeting income eligibility requirements. Even when coverage is available, homeless people may encounter problems negotiating the scheduling systems most mainstream health care providers employ. Finding day labor, a free meal, or a shelter bed are competing priorities for survival, and make it difficult to keep an appointment. Lack of transportation also impedes access to services, as most homeless people don't have cars, and in areas where there is a public transit system, the cost may be prohibitive.

When access to the health care system is finally achieved, most mainstream providers are not organized to deal with the complex issues that are part of being homeless. Usually, the "presenting problem" is treated, leaving the underlying cause of that problem unexamined. Finally, the health care system where services are available is fragmented, organized as a "non-system" that forces clients to travel long distances and negotiate numerous bureaucracies to have a single problem addressed, and hopefully resolved.

In response to the recognition that homeless people tend to fall through the cracks of the mainstream health care system, in 1988 Congress created the Health Care for the Homeless Program, as part of the larger Stewart B. McKinney Homeless Assistance Act. This interdisciplinary, community-based response to the health problems homeless people face brings together a wide range of health care and enabling services such as addiction treatment, behavioral health care, and entitlement counseling. One hundred and twenty-eight federally funded programs across the country deliver care at sites where homeless people congregate, including shelters, soup kitchens, clinics, drop-in centers, and on the street. Health Care for the Homeless Projects have shown that homeless people will utilize primary health care services, but only when providers, services and delivery models are responsive to their needs. Now, ten years later, managed care systems have become a new hurdle that homeless people must overcome.

A New Challenge: Homelessness And Managed Care

Medicaid managed care programs promise to turn the fragmented non-system described above into a sensible system which will ration care appropriately and decrease costs. Features include a medical "home", preventative services, 24-hour telephone access, continuity of care, experienced providers and a seamless delivery system. However, making managed care work for homeless people is much easier said than done because being homeless presents fundamental barriers to accessing services in a managed health care setting.

Homeless people encounter three major challenges when they are enrolled in managed care plans: 1) lack of stability; 2) poor communication dynamics; 3) high prevalence of complex, interrelated health conditions.

1. Lack of stability

The causes of chronic instability in the lives of homeless people are multiple and generally interrelated, though a single cause may suffice to wreak havoc on someone's life. Causes of instability include involuntary relocation within the shelter system, income depletion, substance abuse, loss of entitlements, incarceration, domestic violence, separation from friends and family, or a health crisis. In addition, people usually move in and out of homelessness, enduring episodes that may last weeks, months, and sometimes even years. This time may be spent in a shelter, living doubled-up, or on the street, before finally settling into permanent housing.

2. Poor communications dynamics

Life in a shelter, on the street, in a park or under a roadway seriously impedes communication with the outside world. Homeless people do not have telephones, and those that may be available are not always reliable, affordable, or may allow outgoing calls, but not incoming calls. Mail service for homeless people is irregular and often depends on the good will of friends or family who lend their addresses. When mail is received, low literacy rates and complex content can render information meaningless. Also, many mainstream health care providers are not culturally competent and do not engage clients in an unbiased, accepting manner. Thus, many homeless people must depend on case workers and shelter staff to facilitate

essential communications. As discussed previously, verbal communication with providers is often difficult, shrouded by mutual mistrust, and laden with stereotypes.

3. High prevalence of complex, interrelated health conditions

The health status of some homeless people is markedly inferior to that of traditional Medicaid beneficiaries. Their multiple health problems have been outlined in some detail above. However, not only are homeless people sicker than other Medicaid populations, but many of their conditions are made worse by non-medical factors (such as a lack of good nutrition) which are not usually addressed by managed care organizations. In addition, the living conditions homeless people endure impede rest and compromise hygiene and dietary control. Lack of dietary control and the inability to refrigerate food and medications complicates adherence to drug regimens. Also, life on the street or in shelters can also make possessing psychotropic medications or needles for injecting prescription drugs dangerous.

These three factors taken together -- instability, poor communication, a sick population -- add up to a whole range of practical problems for homeless people enrolled in managed care. Moreover, these problems are exacerbated by the lack of experience most homeless people have in accessing services in a managed care setting. Communication barriers and a lack of information about managed care make the homeless population especially susceptible to marketing abuses by plan representatives. Also, many letters and phone calls are never received, resulting in ineffective outreach and education efforts, auto-assignment to a plan never chosen, and disruptive changes in network providers and coverage. In general, when managed care does work, it is often because enrollees know their rights and are able to effectively communicate with their MCE and its network of providers. Homelessness keeps most of these communications from ever taking place.

It is clear that a significant number of homeless Medicaid managed care enrollees are at risk of losing access to health care. This is not acceptable. However, in spite of these challenges, homeless people are

included in Medicaid managed care programs across the nation. Clearly most states now rely on managed care financing techniques and delivery systems to serve their Medicaid beneficiaries. In their role as purchasers of health care, state governments have the added responsibility of establishing and enforcing the quality and access standards that are set out in contracts with MCEs. However, it is incumbent upon all parties involved (consumers, policy makers, providers, and advocates) to ensure that managed care meets the needs of homeless people. Therefore, such stakeholder groups should be formally incorporated into the state and county-level planning, implementation and monitoring processes.

To help transition homeless people into managed care, a number of strategies should be considered by states, MCEs, health care providers, consumers and advocates. These are presented below in the form of Principles and Illustrative Approaches. The Illustrative Approaches are examples of steps that can be taken en route to achieving the Principles. The Principles and Illustrative Approaches are divided into three sections which follow in this order:

- [protecting the rights of homeless managed care enrollees,](#)
 - [promoting access to an appropriate range of services, and](#)
 - [improving quality of care through responsive payment methodologies and information systems.](#)
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Part II: Strategies for Homeless People in Managed Care

Protecting the Rights of Homeless Managed Care Enrollees

Principle:

A managed care system for homeless people requires flexibility and should not limit choice at the expense of adequate care.

While Medicaid beneficiaries are homeless, they should not be enrolled in managed care programs on a mandatory basis. Rather, managed care enrollment should remain an option for the homeless population. Of course, managed care enrollees should be able to stay with their plan upon becoming homeless, if they so choose. Provider networks which restrict access to "approved" doctors can be problematic for populations with special health care needs such as homeless people. Homelessness can place enrollees geographically out-of-reach of their providers as well as limit phone and mail communications. At a minimum, homeless people should have the ability to access certain frequently used services out-of-network, like behavioral health care and addiction treatment.

Illustrative Approach:

In the State of Washington, homeless Medicaid recipients can receive a temporary (120-day) exemption from enrollment in managed care by providing proof of their shelter or other temporary housing status. This determination is made on a case by case basis and is used with beneficiaries who are homeless *and* expected to reside in a temporary housing situation or homeless shelter for less than 120 days. Under certain circumstances, the exemption can be renewed, but efforts to identify an appropriate provider and plan are encouraged during the exemption period.

Principle:

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

Experience in many states has demonstrated that early and on-going involvement by stakeholders can help facilitate the implementation process. This can be done informally on an ad hoc basis, or by creating advisory boards, task forces or other more formalized structures. Stakeholders who can speak to the needs of homeless people include homeless people themselves, advocacy groups such as 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 between and within states, stakeholders can help the state and local authorities define the characteristics and needs of specific homeless populations and can suggest system accommodations to assure access and quality.

Illustrative Approach:

In the State of New York the legislatively-created *Medicaid Managed Care Advisory Review Panel* (MMCARP) meets monthly to discuss the state's managed care program. Homeless advocates have regularly given testimony at these meetings and have commented on policy documents made available to the public. Included on the Advisory Panel are members of the insurance industry, consumer advocates, and hospital representatives. The panel is mandated to produce a report for the state Legislature and regularly makes recommendations to the New York State Department of Health.

In the State of Tennessee, the *Tennessee Health Care Campaign* has been active in influencing policy formulation and implementation of TennCare. This statewide coalition of health care consumer advocacy groups has met bi-weekly with state officials for the past four years to troubleshoot and suggest policy modifications, where needed. This coalition has given a prominent role to Medicaid beneficiaries, including individuals who are homeless, and has succeeded in making their voices heard by the media and by state officials.

Promoting Access to an Appropriate Range of Services

Principle:

Outreach, education, and ongoing monitoring activities should take place both before and after a homeless beneficiary is enrolled in a plan.

Promoting access to quality health care begins with education and outreach activities prior to enrollment and extends to monitoring on-going utilization of services. A key element for making managed care work for homeless people is an appropriately designed enrollment process. To successfully complete the enrollment process, a viable strategy to identify homeless Medicaid recipients should be developed. The enrollment experience affects everything else, including an appropriate choice of provider, continuity of care, consumer satisfaction, auto-assignment rates, and positive health outcomes. Because auto-assignment is particularly problematic for homeless people, education and outreach, both key components of the enrollment process, should begin long before a homeless Medicaid beneficiary joins a plan. Finally, once enrollment takes place it should be determined 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.

Illustrative Approach:

The YWCA of Seattle, WA has worked in collaboration with the local *Health Care for the Homeless Network* (a part of the Department of Health) to develop the Health Care Access Program for families and individuals who are homeless or at-risk of homelessness. This program provides hands-on, culturally appropriate health coverage and managed care education, application assistance, and advocacy at 25 shelter and transitional housing sites. Through individual counseling sessions and group presentations, "access advocates" explain Medicaid, Healthy Options (a Medicaid managed care program), and Basic Health Plan options, as well as other community resources that meet the health care needs of homeless families and individuals. When

homeless people are enrolled in managed care, advocates help clients address coverage questions, become informed consumers, as well as identify and overcome other barriers to accessing their health care.

Principle:

Managed care plans should demonstrate experience and expertise in delivering the full range of services that homeless people need.

Homeless Medicaid beneficiaries require a service delivery system and benefits package that is responsive to their diverse medical and social service needs. Homeless people should only be enrolled in plans with network providers experienced in delivering culturally appropriate services at locations that are accessible to them, such as soup kitchens, drop-in centers, shelters, and clinics. To link potential enrollees with appropriate providers, states and MCEs must be able to identify homeless Medicaid beneficiaries using a unique identifier prior to enrollment. Also, linkages should be mandated between MCEs and experienced homeless health care providers. Monitoring the strength of a plan's network and determining levels of expertise requires strict oversight activities. Finally, a case manager should be considered most appropriate at the center of service delivery models for homeless people. 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.

Illustrative Approach:

In the Commonwealth of Massachusetts managed care plans are required to pursue clinical initiatives for homeless enrollees that include the development of a case management model. Case management involves the following: 1) creating an "Individual Care Plan"; 2) promoting contact between the enrollee and his/her primary care provider; 3) maintaining linkages with other organizations that are also involved with the enrollee's care; 4) ensuring that case management services are delivered in adult and family shelters; 5) utilizing clinical protocols that meet the needs of homeless people when choosing among treatment and medication options; 6)

developing an inpatient discharge protocol that gives homeless people appropriate options when recovering from illness.

Improving Quality of Care Through Responsive Payment Methodologies And Information Systems

Principle:

Risk-based contracting demands adjustments that reflect the health care costs and utilization patterns of homeless people.

One of the most pressing issues in states right now is how to choose the most appropriate reimbursement methodologies for special populations about whom little reliable data exist. For homeless Medicaid beneficiaries the situation is even more complicated; not only does little or no cost and utilization data exist, but only a few states even attempt to collect such data. 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. If the eventual goal of managed health care systems is a health-based (i.e., risk-adjusted) reimbursement methodology that fairly compensates efficiently run plans, states must begin to collect needed data and develop risk adjustment methodologies that will protect homeless Medicaid beneficiaries. No reimbursement methodology should put MCEs and health care providers at undue risk for providing necessary care to the homeless population.

Illustrative Approach:

Though no state has moved to pay MCEs using risk adjustments based on homeless status, a few states have begun to look at the appropriateness of paying more for individuals who are sicker and tend to incur higher costs. For example, in the State of Maryland eight different rates have been created for mothers and children, eight rates for people with disabilities, as well as an additional rate for people with AIDS. A rate is assigned to an enrollee based on health diagnoses found in claims data. Maryland expects that such an approach makes it less likely that MCEs will avoid enrolling potentially high cost individuals. It is hoped that differential rates will promote innovation and quality.

Principle:

Contracts with plans should describe specific quality assurance activities and outcome measures relevant to the homeless population.

Key quality indicators and data collection processes should be identified that can accurately capture the experiences of homeless people enrolled in managed care. Meaningful indicators and outcome measures should be developed in consultation with experienced homeless health care providers who are familiar with community- and population-specific standards. States should determine which measures have most relevance to homeless people and should carefully monitor those. After determining how homeless Medicaid beneficiaries will be identified, states and MCEs should be able to compare outcomes of their homeless enrollees to those of members who are housed.

Illustrative Approach:

In the State of New York, the Department of Health intends to design a study to assess the quality of care provided to homeless people under its Medicaid Managed Care waiver program. To complete this study, New York State will first develop and pursue strategies to identify homeless individuals who enroll in managed care. The Department of Health plans to enlist the help of organizations that serve homeless people, including food pantries, soup kitchens and others, to identify these individuals. In addition, the appropriateness of linkages between MCEs and homeless shelters will be examined, and whether these linkages have resulted in sufficient access to services.

Conclusion

In searching for the right fit, advocates, policy makers, homeless service providers and homeless people need to identify barriers that must be overcome in order to deliver health care to homeless people in a managed care environment. The challenge to all of us is to ensure that homeless people actually get *all* the care they need.

Bibliography

The Health of Homeless People:

Published Books and Reports

- Baumohl, J. (ed.), et al. *Homelessness in America*. Phoenix, AZ: Oryx Press, 1996.
- Brickner, P.W. (ed.), et al. *Health Care of Homeless People*. New York: United Hospital Fund, 1985.
- Brickner, P.W. (ed.), et al. *Under the Safety Net: The Health and Social Welfare of the Homeless in the United States*. New York: W.W. Norton, 1990.
- Burt, M. And Cohen, B. *America's Homeless: Numbers, Characteristics, and Programs That Serve Them*. Washington, DC: The Urban Institute, 1996.
- Care for the Homeless. *Can Managed Care Work for Homeless People?: Guidance for State Medicaid Programs*. New York, 1998.
- Cousineau, M., Wittenberg, E. And Pollatsek, J. *A Study of the Health Care for the Homeless Program: Final Report*. Washington, DC: Bureau of Primary Health Care, 1995.
- McMurray-Avila, M. *Organizing Health Services for Homeless People*. Nashville, TN: National Health Care for the Homeless Council, 1997.
- National Coalition for the Homeless. *Fact Sheet #2 - How Many People Experience Homelessness?* Washington, DC: NCH, 1997.
- Neibacher, S. *Homeless People and Health Care: An Unrelenting Challenge*. New York: United Hospital Fund, 1990.
- Robertson, M.J. and Greenblatt, M. (eds.) *Homelessness: A National Perspective*. New York: Plenum Press, 1992.
- Vissing, Y. *Out of Sight, Out of Mind: Homeless Children and Families in Small Town America*. Lexington, KY: University Press of Kentucky, 1996.

Managed Care, Medicaid, Homelessness and Related Topics:

Published Reports

- Dreyfus, T., Kronick, R. and Tobias, C. *Using Payment to Promote Better Medicaid Managed Care for People with AIDS*. National Academy for State Health Policy, July 1997.
- Kronick, R. and Dreyfus, T. *The Challenge of Risk Adjustment for People with Disabilities: Health-Based Payment for Medicaid Programs: A Guide for State Medicaid Programs, Providers, and Consumers*. Center for Health Care Strategies, Inc., November 1997.

The following guides to Medicaid managed care are available from Families USA:

- *A Guide to Marketing and Enrollment in Medicaid Managed Care;*
- *A Guide to Meeting the Needs of People with Chronic and Disabling Conditions in Medicaid Managed Care;*
- *A Guide to Complaints, Grievances, and Hearings Under Medicaid Managed Care;*
- *A Guide to Access to Providers in Medicaid Managed;*
- *A Guide to Cost-Sharing and Low-Income People.*

Government Documents and Reports:

- U.S. General Accounting Office, Health, Education, and Human Services Division. *Medicaid Managed Care: Serving the Disabled Challenges State Programs*. GAO/HEHS-96-136. Washington, DC: U.S. General Accounting Office, July 1996.

Articles in Journals and Anthologies:

- Kronick, R., Zhou, Z. and Dreyfus, T. "Making Risk Adjustment Work for Everyone." *Inquiry* 32: 41-55, Spring 1995.