



## From Health Care to Housing: Maximizing Medicaid for People Who Are Homeless

*Pre-Conference Institute, May 6, 2015*  
*Key Points from Conversations*

### *Session 1: Efforts to expand Medicaid in non-expansion states*

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1. Need to engage housing providers and other stakeholders (e.g., Chambers of Commerce, sheriffs/justice community, etc.) in advocacy efforts
2. Use politically helpful language (i.e., “our unique state solution”)
3. Continue to focus on gaps in coverage and the ramifications of being uninsured (both morally and financially)
4. In all states, ensuring the enrollment system works for all those who are Medicaid-eligible (e.g., re-entry population, those with no income and/or credit histories, citizens who lack documentation, etc.).

### *Session 2: The role of traditional funding sources*

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1. Need to map current funding and services covered
2. Balance need for diversified funding with administrative burdens of multiple reporting/auditing/etc.
3. Need for HUD HMIS-EHR guidance to assist with data exchange, address privacy issues, and ease burden of double data entry
4. Balance productivity with access & quality, establish new baseline measures and other data
5. Need for ACT model for non-SMI populations that are also high need and would benefit from this evidence-based approach
6. **ACTION: The Council will work with federal partners to establish follow-up discussion on how non-Medicaid funding streams can best meet ongoing needs**

### *Session 3: New delivery systems, managed care organizations, and the role of Medicaid in PSH and medical respite care*

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1. Provide guidance to MCOs about how to identify homelessness among beneficiaries using the ICD-10 code for homelessness (Z59.0) and assign to appropriate providers (e.g., HCH providers or others)
2. Bring MCOs together in one summit at state level to educate and establish common approaches
3. Educate supportive housing providers about Medicaid and health care services
4. Standardize contracting mechanism for medical respite care
5. Talk with MCO and state Medicaid leadership earlier rather than later, without need to have established answers to all questions
6. Talk about supportive services needed by homeless persons using existing language and Medicaid benefits, such as “personal care” and other benefits available to seniors and those with disabilities (rather than suggesting a totally new benefit or population)
7. Workforce issues such as training in evidence-based practices, the importance of peer supports/community health workers/case managers/care coordinators, manageable caseloads, and prevention of burn-out are critical to address in budget and operational decisions
8. Ensure mutual understanding when using common terminology given various interpretations (e.g., service coordination, care coordination, case management, etc.)
9. Frame discussions about homelessness with Medicaid directors in terms that focus on service use, such as “super users,” “high-cost, high-need” or other terms, rather than something vague like “homeless.”
10. Materials from HHS such as ASPE reports on Medicaid and PSH and the upcoming CMS Info Bulletin on supportive services are designed to be helpful to providers and policy makers at state and local levels. A HRSA document to health centers may not be needed given this information.
11. Advocacy with Congress around additional resources for mainstream affordable housing is essential.
12. Primary care associations can help create a culture of coding for homelessness at all health centers to better document number of patients across all grantees. ICD-9 = V60.0. ICD-10 = Z59.0.
13. Hospitals and the role of community benefit funds should also be a part of this conversation.