

**"Optional Purchasing Specifications:
Medicaid Managed Care for Individuals Who Are Homeless"**

**Prepared by the George Washington University Center for Health Services
Research and Policy (CHSRP)
in consultation with
The Health Resources and Services Administration (HRSA),
including the Health Care for the Homeless (HCH) Branch of the Bureau of
Primary Care**

June 2000

(Edited introductory material)

This document, "Optional Purchasing Specifications: Medicaid Managed Care for Individuals Who Are Homeless" was prepared by the George Washington University Center for Health Services Research and Policy (CHSRP) in consultation with officials from the Health Resources and Services Administration (HRSA), including the Health Care for the Homeless (HCH) Branch of the Bureau of Primary Care. This technical assistance document should be viewed as a tool to assist state officials in purchasing services from managed care organizations (MCOs) on behalf of individuals who are homeless and who are eligible for Medicaid.

These sample purchasing specifications are optional, and do not necessarily reflect the views of HRSA or the Health Care Financing Administration (HCFA).

In a recent guidance for state Medicaid programs, Wunsch notes, "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."¹

There is no requirement under current federal law that state Medicaid programs enroll Medicaid beneficiaries who are homeless in managed care plans. States operating Medicaid managed care programs have the option of excluding homeless beneficiaries from enrollment in MCOs and covering them on a fee-for-service basis. Research conducted by CHSRP described below found that in 1997, the Medicaid MCO contracts of some States contained provisions excluding homeless individuals as a group (e.g., Maine) or on a case-by-case basis (e.g., New York) from enrollment.

Organization and Structure of This Technical Assistance Document

These optional specifications assume that individuals who are homeless at the time they enroll in an MCO, or who become homeless after enrolling, are eligible for Medicaid. This assumption is made because almost all homeless individuals are poor, and because Medicaid is the only national source of health care financing for the poor that can make capitation payments on their behalf to MCOs. This is not to say that all

homeless individuals are eligible for Medicaid; they are not. In order to qualify for Medicaid in most states, an individual must not only be poor, but must fit into one of the following categories: families with children, elderly, or disabled. Thus, single, non-disabled adults under age 65, and childless couples are not eligible for Medicaid in most states, regardless of their level of impoverishment. (Some states with Medicaid demonstration waivers under section 1115 of the Social Security Act extend Medicaid coverage to this population).²

This document is divided into two Parts. **Part 1** sets forth the covered services for enrollees who are homeless and eligible for Medicaid. Part 1 also includes suggested language relating to case management services for the homeless, including the development and implementation of an individual care plan. Finally, Part 1 includes specifications regarding guidelines for the delivery of such services and coverage determination standards and procedures as they affect enrollees who are homeless.

Part 2 contains illustrative language relating to the delivery of services to enrollees who are homeless. This includes specifications on enrollment, provider selection, provider network, access standards, data, and enrollee safeguards. Part 2 also contains illustrative language regarding clinical studies on the quality of services furnished to homeless enrollees and memorandum of understanding elements relating to homeless enrollees.

The logic of this format is as follows. First, there is no universally accepted drafting format for Medicaid purchasing agreements; instead, each state has its own approach. In order to be useful to as many interested states as possible, illustrative specifications such as those in this document must be organized into segments of manageable size that are readily accessible to different potential users.

Second, much of the federal policy and the science in this area has been evolving and will continue to do so. The format of this technical assistance document allows new developments in any one issue area to be incorporated into the relevant section without redrafting the remainder of the document.

Finally, contracts or agreements between purchasers and MCOs tend to cover a wide range of substantive issues. The format of these specifications is designed to facilitate the drafting and negotiation of these documents. In short, the individual sections are portable to enable the parties to refer to those provisions for which they need technical assistance.

These sample specifications are designed for numerous users including: agencies that want to construct a new purchasing document; agencies that have a purchasing document in use but wish to modify it; public health agencies, other state and local agencies, and constituency groups that want to provide technical assistance to the purchasing agency; and MCOs. Consumers and health care providers also should find this document useful in helping them identify key issues in managed care contracting.

As noted above, the language suggested throughout this document is optional for interested purchasers. In some case, alternative options are presented in footnotes in order to highlight different policy choices available to purchasers.

How to Use This Technical Assistance Document

The illustrative language in this document is drafted to minimize ambiguity and maximize clarity. The more clearly an MCO understands what is expected of it by the purchaser, and the more clearly a purchaser understands what the MCO is obligating itself to provide, the more likely it is that any agreement between the two parties will be carried out to the mutual satisfaction of each and will be likely to benefit the homeless Medicaid beneficiaries enrolled with the MCO.

The drafting format used in these sample specifications is as follows:

- Each Part is divided into sections, identified by "§".
- Each section, in turn, is divided into one or more subsections: "(a)", "(b)", etc.
- A subsection may be divided into one or more paragraphs: "(1)", "(2)", etc.
- A paragraph may be divided into one or more subparagraphs: "(A)", "(B)", etc.
- A subparagraph may be divided into one or more clauses: "(i)", "(ii)", etc.

Every state purchaser has its own drafting format. The particular format used in these sample specifications is NOT intended as a substitute for each state's own format. Instead, it is intended simply to divide each suggested provision into the smallest practicable policy elements. This division and subdivision format is designed to enable a user to identify quickly the policy choices contained in each provision and to identify which, if any, of the elements the user wishes to adopt. This format also serves as a detailed checklist for those users who wish to compare portions of their current purchasing documents with the relevant portions of these sample specifications. For example, assume a state purchaser uses the following contract language relating to geographic access to primary care physicians:

"6.6.1 Time and Distance Standard: Contractor will maintain a network of Primary Care Physicians which are located within thirty (30) minutes or ten (10) miles of a Member's residence unless the Contractor has a DHS-approved alternative time and distance standard."

Assume further that this purchaser intends to enroll individuals who are homeless in managed care, and that, in order to better evaluate the cost and feasibility of the access standards to which they would be held accountable, potential contractors have requested greater specificity with respect to time and distance standards for Members without residences. In this case, an interested purchaser could use §204(b) of these specifications:

"(b) Location of Primary Care Providers -- Contractor shall ensure that at least [] primary care providers (as defined in §107(j)) participating in Contractor's provider network under §203(a) practice at sites that are:

- (1) accessible by public transportation; and

(2) located within [] minutes by public transportation of the soup kitchen, drop-in center, shelter, or other location frequented by the enrollee."

In order to include this homeless-specific policy in its contract, the purchaser could, without modifying its current language, adapt the illustrative language to its own drafting format as follows (italicized):

"6.6.1 Time and Distance Standard-- Contractor will maintain a network of Primary Care Physicians which are located within thirty (30) minutes or ten (10) miles of a Member's residence unless the Contractor has a DHS-approved alternative time and distance standard. In the case of a Member who is homeless, Contractor will ensure that at least [] Primary Care Physicians in the network practice at sites that are (1) accessible by public transportation and (2) located within [thirty (30) minutes] by public transportation or [ten (10) miles] of the soup kitchen, drop-in center, shelter, or other location frequented by the Member."

Endnotes

1. D. Wunsch, Can Managed Care Work for Homeless People: Guidance for State Medicaid Programs, p. 1, <http://www.nhchc.org/guidance.html>. See also J. Singer, Health Care for the Homeless, Baltimore, MD, The Safety Net: Research and Reality (June 3, 1999), regarding the experience of health care for the homeless providers with Medicaid managed care in Maryland: "[t]he sole provider [of homeless health care] in the State has lost hundreds of thousands of dollars and been forced to turn away hundreds of individuals. As the numbers of the uninsured grow, safety net providers must serve more individuals with reduced care. Medicaid payments supplemented inadequate funds available for the uninsured (e.g., targeted Federal programs and block grant dollars). Today, these funds for the uninsured are supplementing inadequate Medicaid payments."
2. For an overview of Medicaid eligibility rules for families with children and for individuals with disabilities, see A. Schneider, K. Fennel, and P. Long, Medicaid Eligibility for Families and Children (September 1998), and A. Schneider, V. Stohmeyer, and R. Ellberger, Medicaid Eligibility for Individuals with Disabilities (July 1999), Kaiser Commission on Medicaid and the Uninsured, <http://www.kff.org>.
3. For suggested language on these and other general provisions, see: Wendy L. Krasner, "Government Contracts in Managed Care," in Critical Steps in Managed Care Contracting: A Looseleaf Guide, National Health Lawyers Association, 1995; NHLA/AAHA Practice Guide Series, Volume 1: Managed Care Contracting Handbook, 1997, <http://www.healthlawyers.org>; Medimetrix Consulting, "Medicaid Managed Care Contracting Guide," August 1997, Center for Health Care Strategies, Inc., <http://www.chcs.org>; and Jane Perkins and Kristi Olson, "An Advocate's Primer on Medicaid Managed Care Contracting" 31 Clearinghouse Review 19 (May/June 1997).