

**Office of Health Insurance Programs**  
**Policy and Guidance to Transition the Homeless Population into Medicaid**  
**Managed Care**  
**April 2012**

The NYS Department of Health will begin mandatory enrollment of the homeless population in April 2012. The Department has had several stakeholder workgroup meetings with managed care plans, providers, shelters, State agencies and local districts to identify obstacles and opportunities that will affect the enrollment of this population. The main issues have been broken into four major areas: Enrollment and Phase-in, Care Management, Access to Services, Contract and Credentialing. This document reflects the policy decisions that have been developed to respond to issues raised.

**I. Enrollment/Disenrollment and Phase-in**

Enrollment Phase –In

The phase-in for mailings will occur over a 6 month period beginning April, 2012, using three phases in New York City over the change/recertification cycle. Mailings will be established utilizing information received from DHS of persons residing in DHS shelters, as well as persons checking into soup kitchens, drop-in centers, and HRA job centers. The roll out will occur as follows:

**Phase 1**

FAMILIES

April	Bronx, Manhattan
May	Brooklyn, Queens, SI

**Phase 2**

SINGLE ADULTS/ADULT FAMILIES

June	Bronx, Manhattan
July	Brooklyn, Queens, SI

**Phase 3**

STREET HOMELESS (UNDOMICILED)

August/September	All boroughs
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Mailings will be spread over the course of the months outlined above. Persons will be given 30 days to choose a health plan or will be auto-assigned (AA) using the state's approved AA algorithm. NY Medicaid Choice staff will be utilized in specified shelter locations during the phase-in to assist persons to choose a plan. In addition, homeless shelters, providers of the homeless and stake holders will be trained in the process for further assistance in choosing a plan.

If NY Medicaid CHOICE or the LDSS mails an enrollment packet and the packet is returned due to bad address etc., the LDSS is responsible to attempt to locate the client to confirm the updated address. If the LDSS cannot locate the client and has no other means of contact with the client, there will be NO auto-assignment.

#### Additional activities to be conducted

Below are additional activities that will occur to assist with the enrollment of the homeless population.

1. Provide phone numbers and contact information of NY Medicaid CHOICE, local district and CBO FEs who can assist with application and/or enrollment. Providers and shelters in upstate counties will work closely with the local districts/NY Medicaid CHOICE in the enrollment process of this population. Many local districts tend to know this population through the TA worker.
2. Providers and/or shelter staff can act as authorized representatives at the client's request to assist this population in the application and/or enrollment/transfer process.
3. In NYC, CBO Facilitated Enrollers (FEs) will be used at shelters to assist the homeless population with application and/or enrollment, and plan FEs will be used at HRSA sites. NY Medicaid CHOICE will have a presence at shelters to educate Medicaid consumers on the right option for them and their rights.
4. In NYC, the DHS file will be amended to delineate families from singles, and add the "street homeless" as identified from sign-ins at soup kitchens, mobile medical units and drop-in centers.
5. Warm enrollment will be allowed. A "warm enrollment" occurs when a third party assists a client to contact the LDSS or NY Medicaid CHOICE for education and enrollment and stays on the phone through a 3-way during the transfer to assist the client with the beginning stages of contact with the LDSS/broker staff person.
6. Provide shelters with a list of plans that contract with their affiliated providers/clinics to assist the shelters in working with the client for potential enrollment. Providers, shelters, etc. should encourage the homeless to pick a plan while they are there to avoid auto-assignments.
7. In NYC - DHS case managers will assist in explaining the process of enrollment to clients and will assist them in contacting NY Medicaid CHOICE to educate and enroll. For the undomiciled, DHS street case managers will bring the street homeless to the drop-in centers on designated days. On those designated days, CBO FEs and NY

Medicaid CHOICE will be deployed there to assist in the application, education and enrollment process.

### Stakeholder Training

1. Stakeholder webinar for providers and other stakeholders was held on March 7, 2012. That webinar can be accessed at the following link:  
[http://www.health.ny.gov/health\\_care/managed\\_care/appextension/docs/webinar\\_new\\_populations\\_and\\_benefits.pdf](http://www.health.ny.gov/health_care/managed_care/appextension/docs/webinar_new_populations_and_benefits.pdf)
2. Training rollout began in January (Managed Care 101 - Choosing a Plan)
3. Posters/fliers for community settings have been developed and printed and are being shipped to all the LDSS for distribution.

### Plan Disenrollment

1. Good cause disenrollment during the lock-in period will be modified to include the following provisions:
  - a. The client is placed in a shelter system that is not in the plan's service area.
  - b. The client is placed in a shelter that provides on-site services and the shelter provider does not have an affiliation with the enrollee's managed care organization or the enrollee is receiving services from a clinic that does not participate in the enrollee's plan, and the member wishes to receive primary care services at that site. The member will be allowed to enroll in a plan that participates with that clinic provider upon request.
2. All disenrollments and enrollments will be effective the first day of the following month as long as the request was made prior to pull down, which is normally the third Friday of the month. Members or their designee can call Medicaid CHOICE to effectuate this change.
3. MCOs are responsible, per the managed care contract, to report to the LDSS (or HRA) all new enrollees that the plan is unable to reach in the initial months of enrollment (90 days) and who have not received any services since enrollment.
  - a. Also included in the contract is the responsibility for the MCO to report to the county any change in a client's status which includes address change and/or inability to contact.
  - b. Upon receipt of this report, the LDSS must act on the information provided by the plan which may include follow-up to locate the client if the plan is reporting that they are unable to reach the client.

## **II. Care Management**

Concern has been raised as to whether plans will further expand case management activities to respond to the needs of this population. In addition, issues were raised regarding the impact of Health Homes in the provision of services.

MCOs will be required to enhance and extend their case management activities for those individuals who will not participate in the State's Health Home initiative. All homeless populations will not meet the requirement for health home enrollment due to CMS specifications. In addition, since the characteristics of the homeless have changed, all may not need case management from plans, however, MCOs will have to enhance their efforts to identify those persons who would benefit from care management and ensure that mechanisms are in place to offer assistance with coordination of services for the high risk homeless population. The following are activities that will assist with the management of this population.

1. MCOs receive an e-file from NY Medicaid CHOICE which will include a homeless indicator to identify a person as homeless if the client is either on the DHS file or has called to enroll through the enrollment broker and has self identified as homeless.
2. Health Plans will use news letters, provider manuals or other means to encourage providers to refer enrollees to case management programs when there is a need, resulting from an assessment. Information as to where to call should also be identified for all in order to refer accordingly.
3. Health plans will accept referrals from multiple sources regarding the need to enroll a client into internal and external case management programs.
4. Contact information for plans and shelters has been shared in order for both to communicate information relating to enrolled members.

## **III. Access to Services**

Several issues were raised regarding access to services for the homeless population. Managed care can potentially improve the continuity of services provided. However, due to the vulnerability of the homeless population, several policies have been adjusted to allow homeless individuals to obtain access to needed services close to the shelter where they may reside.

### Initial Visit at Non-Participating Provider

Non-participating providers must seek authorization from MCOs for the initial visit of the homeless and for any follow-up care. The initial visit of the homeless will be approved by the plan promptly in order for the homeless member to receive timely treatment. The DOH maintains a managed care complaint hotline for members and providers at 1-800-206-8125.

1. If a homeless enrollee is seeking care from a non participating provider due to the proximity to the shelter, the provider will need to request authorization from the MCO to conduct an assessment or provide urgent care to the enrollee.
2. Health Plans must develop a process to receive authorization requests and render a determination in a timely manner so as not to delay an initial visit.
3. Health plans will approve the initial visit when a homeless enrollee presents at a non-participating shelter provider or non participating community provider, which does not participate in the plan, but participates in the Medicaid fee-for-service program.
4. For an assessment, the plan will reimburse the non participating provider at the fee-for service non-facility global fee for E&M (evaluation and management) code 99203.
5. Any follow-up and/or specialty care needed must be prior authorized by the plan or referred by the PCP to a participating provider. If urgent care is needed, the MCO must consider whether any delay in seeking treatment may result in the member not accessing care, and should, in that case, authorize. The provider must seek authorization on the next business day if care was provided during non-business hours.
6. Non participating providers will be required to use the plans participating pharmacies, laboratories, inpatient and outpatient providers for the provision of services and should be arranged by provider and plan.
7. Nothing in this section modifies the FQHC wrap payment policies or process. The FQHC wrap is only available to the FQHC if they have a contract with the MCO.

### Primary Care Provider

1. Plans will allow enrollees or their designee to change PCPs , upon request, in the following situations:
  - a. MCO will facilitate changing enrollee’s PCP assignment to participating shelter provider upon member request, or
  - b. MCO will facilitate changing enrollee’s PCP assignment to a PCP closer to shelter location upon member request , or

- c. MCO will work with FE, local district, or Medicaid CHOICE to disenroll and enroll (transfer) homeless member into another plan in order to continue the relationship with a provider, if the provider does not participate in the plan.
2. Providers at homeless shelters may function as PCPs for the homeless population if their total hours worked at all locations amount to a minimum of 16 hours weekly. This is only for the homeless population who wish to use the providers at the shelter sites. MCOs do not have to show these providers in their provider directories as PCPs since it is limited to the homeless population. All other PCPs must adhere to the requirements in the Model contract. The MCO should let the enrollee know that the shelter providers are available as PCPs even though they are not listed in the directory.

#### **IV. Contracting and Credentialing**

1. MCOs are required to contract with at least two Section 330H providers per county, where they are available. If no Section 330H providers exist in the county, the plan must enter into contract with FQHCs and providers who traditionally provide services to this population.
2. MCOs are required to comply with Article 4406-d of the PHL regarding the credentialing of providers. That provision states in part “ A health care plan shall complete review of the health care professional’s application to participate in the in-network portion of the health care plan’s network and shall, within ninety days of receiving a health care professional’s completed application to participate in the health care plan’s network, notify the health care professional as to whether he or she is credentialed or whether additional time is necessary to make a determination in spite of the health care plan’s best efforts or because of failure of a third party to provide necessary documentation, or non-routine or unusual circumstances require additional time for review.”