DEPARTMENT OF HEALTH & HUMAN SERVICES
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Center for Medicaid and State Operations
Disabled and Elderly Health Programs Group (DEHPG)

TO: State Medicaid Directors
CMS Associate Regional Administrators for Medicaid

CC: Charlene Brown, CMSO Deputy Director

FROM: Glenn Stanton
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SUBJ: Ending Chronic Homelessness

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The United States Interagency Council on Homelessness, recently chaired by HHS Secretary Thompson, is working to develop and implement a comprehensive national approach to end chronic homelessness in the United States through interagency, intergovernmental, and intercommunity collaborations. CMS has been supporting the efforts of the council in several ways. First, we worked with our federal partners to release a new tool on our website entitled *First Step on the Path to Benefits for People who are Homeless.* The *FirstStep* product is an easy-to-use, interactive tool designed to assist case managers and outreach workers in helping people who are homeless to gain access to mainstream programs. The tool may be found on the CMS website at http://www.cms.hhs.gov/medicaid/homeless/firststep/index.html.

Second, I am pleased to announce that we have posted a report on our website that is entitled *Improving Medicaid Access for People Experiencing Chronic Homelessness: State Examples*. This report focuses on practices that have increased Medicaid access for people experiencing chronic homelessness, including assisting people leaving psychiatric facilities and correctional facilities to obtain Medicaid quickly. We hope this report will provide useful information about state efforts as you address chronic homelessness issues in your state. The report may be found on CMS's website at http://www.cms.hhs.gov/promisingpractices/ or at http://www.cms.hhs.gov/medicaid/homeless/.

Finally, CMS is encouraging states with this letter to "suspend" and not "terminate" Medicaid benefits while a person is in a public institution or Institute for Mental Disease (IMD). Persons released from institutions are at risk of homelessness; thus, access to mainstream services upon release is important in establishing a continuum of care and ongoing support that may reduce the demand for costly and inappropriate services later.

As a reminder, the payment exclusion under Medicaid that relates to individuals residing in a public institution or an IMD does not affect the *eligibility* of an individual for the Medicaid program. Individuals who meet the requirements for eligibility for Medicaid may be enrolled in

the program before, during, and after the time in which they are held involuntarily in secure custody of a public institution or as a resident of an IMD. The statutory federal financial participation (FFP) exclusion applying to inmates of public institutions and residents of IMDs affects only the availability of federal funds under Medicaid for health services provided to that individual while he or she is an inmate of a public institution or a resident of an IMD.

Thus, states should not terminate eligibility for individuals who are inmates of public institutions or residents of IMDs based solely on their status as inmates or residents. Instead, states should establish a process under which an eligible inmate or resident is placed in a suspended status so that the state does not claim FFP for services the individual receives, but the person remains on the state's rolls as being eligible for Medicaid (assuming the person continues to meet all applicable eligibility requirements). Once discharge from the facility is anticipated, the state should take whatever steps are necessary to ensure that an eligible individual is placed in payment status so that he or she can begin receiving Medicaid-covered services immediately upon leaving the facility. If an individual is not already eligible for Medicaid prior to discharge from the facility, but has filed an application for Medicaid, the state should take whatever steps are necessary to ensure that the application is processed in a timely manner so that the individual can receive Medicaid-covered services upon discharge from the facility.

Given the high incidence of substance abuse, mental illness, and physical illness among those who have been incarcerated or otherwise held in involuntary custody, I encourage states to coordinate prison health services and other health care services provided during involuntary confinement with Medicaid services. By working with parole officers and other social services professionals who deal with inmates and residents of IMDs who are to be released, State Medicaid programs can assure that eligible persons are enrolled in Medicaid prior to release and can create an ongoing continuum of care for these individuals, regardless of the source of funding for such care.

In closing, I want to thank you for your ongoing efforts to improve access to Medicaid for all persons, and particularly for those who are homeless.