Affordable Care Act: Medi-Cal Opportunities and Challenges
An analysis for the Conrad N. Hilton Foundation’s four domestic programs

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April 2014
Table of Contents

Acknowledgements .............................................................................................................. ......................................... 3
Introduction ......................................................................................................................................................... 4

Substance Abuse Prevention and Early Intervention .............................................................. ........................................................................................................... 5
ACA: New Medi-Cal SBIRT Benefit for Alcohol Misuse .............................................................. ........................................................................................................... 5
  Covered Services ................................................................................................................................. 6
  Provider Restrictions ........................................................................................................................... 7
Challenges to Implementation of SBIRT and Work Flow Issues .............................................. ........................................................................................................... 8
Why Did California Not Extend the Medi-Cal SBIRT Benefit to Youth Beneficiaries? .......... ........................................................................................................... 8
Is Screening and Brief Intervention for Substance Use Covered under Medi-Cal EPSDT Program? ........................................................................................................... 9
Medicaid SBIRT Benefit in Other States ....................................................................................... ........................................................................................................... 10
Additional Resources .............................................................................................................................. ........................................................................................................... 12
Ending Chronic Homelessness ............................................................................................................. ........................................................................................................... 14
ACA: Opportunities to Prevent and End Chronic Homelessness .................................................. ........................................................................................................... 14
  Expand Eligibility ............................................................................................................................. ........................................................................................................... 15
  Expansion of Mental Health and Substance Use Disorder Services ............................................ ........................................................................................................... 16
  Enhanced Integrated Service Delivery ............................................................................................. ........................................................................................................... 16
ACA Implementation Challenges for People Experiencing Chronic Homelessness .................. ........................................................................................................... 19
  Enrollment Barriers ............................................................................................................................ ........................................................................................................... 19
  Expanded Substance Use Disorder Services and Provider Capacity Challenges .......................... ........................................................................................................... 20
  Achieving a Robust, Integrated Delivery System Barriers ............................................................... ........................................................................................................... 21
  Potential Challenges with the Reduction of County Funds for Indigent Health Care .................. ........................................................................................................... 21
  Medicaid Health Homes Option and Implementation Challenges ............................................... ........................................................................................................... 22
Promising Practices to Overcome Enrollment Barriers ..................................................................... ........................................................................................................... 22
Additional Resources .............................................................................................................................. ........................................................................................................... 25
Supporting Transition-Aged Youth in Foster Care ........................................................................ ........................................................................................................... 27
ACA: Push Towards Access and Equity for Foster Youth .............................................................. ........................................................................................................... 27
  Expand Medi-Cal Coverage from Age 21 to 26 ............................................................................ ........................................................................................................... 28
  Simplified Redetermination Process .............................................................................................. ........................................................................................................... 30
Challenges to Medi-Cal Enrollment for Former Foster Youth ....................................................... ........................................................................................................... 31
  Identification of Aged-Out Foster Youth .......................................................................................... ........................................................................................................... 31
  Barriers to Enrollment ...................................................................................................................... ........................................................................................................... 31
Promising Practices: Outreach and Enrollment ............................................................................... ........................................................................................................... 32
Additional Resources .............................................................................................................................. ........................................................................................................... 35
Overcoming Multiple Sclerosis .......................................................................................................... ........................................................................................................... 37
Additional Resources .............................................................................................................................. ........................................................................................................... 37
Acknowledgements

I would like to gratefully acknowledge the contributions of the Program Officers at the Conrad N. Hilton Foundation (Jeannine Balfour, Alexa Eggleston, Andrea Iloulian, and Elizabeth Cheung), who provided thoughtful input and guidance on this project. I would also like to thank Jessica Haspel of Children Now, Rusty Selix of the Mental Health Association in California, Sharon Rapport of the Corporation for Supportive Housing, and Stewart Ferry of the National Multiple Sclerosis Society for their expertise and ongoing consultation. Finally, I would like to thank my supervisor, Bill Pitkin, Director, Domestic Programs at the Conrad N. Hilton Foundation for his continued support, guidance, and encouragement throughout this project.
Introduction

The Affordable Care Act (ACA) is considered to be the most significant piece of health care reform legislation in the history of the United States since the authorization of Medicaid and Medicare in the 1960’s. Enacted in March 2010, the ACA aims to improve access to health care, increase the breadth and scope of services for consumers, and enhance funding opportunities to improve the delivery of care and systems. Millions of persons in the United States are expected to receive health care coverage as a result of this legislation.

The Conrad N. Hilton Foundation is researching how health care reform in California will impact its four domestic programs: Substance Abuse Prevention and Early Intervention, Ending Chronic Homelessness, Supporting Transition-Age Foster Youth, and Overcoming Multiple Sclerosis. Each program area has specific questions and concerns about the implementation of health care reform in California, from the enrollment process to the delivery of extended mental health and substance use disorder services.

This report highlights opportunities as well as challenges under the ACA to improve access to Medicaid health care coverage, enhance integrated and coordinated care, and overall, augment life outcomes and well-being for these populations. The report also discusses the associated challenges of the ACA implementation, such as barriers to Medi-Cal enrollment for persons who are chronically homeless and former foster youth. Each section of the report highlights promising practices to overcome some of these implementation challenges.
Substance Abuse Prevention and Early Intervention

Recognizing adolescence is a critical period to prevent substance use disorders and the potential lifetime consequences of early substance misuse and addiction, the Conrad N. Hilton Foundation established the Substance Abuse Prevention and Early Intervention initiative in the summer of 2013. The initiative strives to improve the substance abuse outcomes of youth and young adults between the ages of 15 and 22 through prevention and early interventions. One early intervention the Foundation is particularly focused on is Screening, Brief Intervention, and Referral to Treatment (SBIRT). SBIRT is defined by the Substance Abuse and Mental Health Services Administration (SAMHSA) as “a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for individuals with substance use disorders, as well as those who are at risk of developing these disorders.”

The model is based on the concept that primary care centers, hospital emergency rooms, trauma centers, and other community settings provide opportunities for early intervention before more severe consequences occur. Subsequently, this approach seeks to provide early intervention and bridge prevention and treatment in order to stop addiction before it develops.

The enactment of the Affordable Care Act (ACA), along with California’s decision to select the Medicaid Expansion Option, raised questions for the Foundation on the potential opportunities to enhance the implementation of the SBIRT model for youth in California. Specifically, staff was interested in understanding whether or not health care reform would provide an opportunity to add SBIRT as a reimbursable Medi-Cal benefit for youth. If not, which states allow screening and brief intervention services for substance abuse to be a billable service under Medicaid? The Foundation was also interested in understanding to what extent Medicaid’s child health component, known as the Early and Periodic Screening, Diagnosis and Treatment program (EPSDT), covered the benefit.

The following section first provides an overview of the new Medi-Cal SBIRT benefit, followed by the challenges to implementing the new benefit. The section also discusses the limitations in the new Medi-Cal SBIRT benefit. Lastly, it highlights other states that offer the SBIRT benefit to adolescents under Medicaid.

ACA: New Medi-Cal SBIRT Benefit for Alcohol Misuse

The Affordable Care Act serves to improve health outcomes by promoting prevention, wellness and health. Several provisions outlined in the ACA provide local and state agencies the

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1 According to the U.S. Preventive Task Force, alcohol misuse refers to engaging in risky and harmful drinking that could lead to long-term health consequences. Risky and harmful drinking is more than seven drinks per week for women and more than 14 drinks per week for men.
opportunity to increase and strengthen the delivery of preventive and early identification services, including Screening, Brief Intervention and Referral to Treatment (SBIRT).

Under the ACA, states that elect to cover all prevention services recommended by the United States Preventative Task Force (USPSTF) at no cost to Medicaid beneficiaries are eligible to receive an increased federal match for those services. In May 2013, the USPSTF recommended screenings and brief behavioral counseling interventions to reduce alcohol misuse for adults 18 and older. Based on this recommendation, the state of California decided to make Screening, Brief Intervention and Referral to Treatment (SBIRT) for alcohol misuse a qualified Medi-Cal benefit.

Historically, California’s Medi-Cal program has covered and provided reimbursement for screening and brief intervention services for drug and alcohol misuse among beneficiaries who are pregnant or women of childbearing age. Effective January 2014, Medi-Cal Managed Care Plans must extend the SBIRT benefit to all beneficiaries over the age of 18 who meet the medically necessary criteria for Medi-Cal Mental Health Services. This new benefit must be incorporated into mainstream health care settings, including primary care settings and trauma centers. By integrating alcohol screenings into the primary care setting, health care practitioners have the opportunity to identify persons with, or at-risk for alcohol-related substance use disorders, and provide the appropriate level of intervention.

Separate from the Medi-Cal program, the California Department of Alcohol and Drugs received a grant of $17.4 million (over five years) in 2003 from the Substance Abuse and Mental Health Services Administration (SAMHSA) to be a part of a national SBIRT demonstration project. Administered by the San Diego County Alcohol and Drug Services and San Diego State University Research Foundation, the project was designed to target the general population during primary care medical visits. In 2008, the project was expanded to target short-term detainees in the Los Angeles County or city jails. Although the pilot showed favorable outcomes, the grant was not renewed in 2009.

**Covered Services**

Medi-Cal Managed Care Plans, or Fee-For-Service in areas where Managed Care is not available, provide reimbursement for SBIRT services. Reimbursable services include one full screening and three brief intervention sessions per patient, per calendar year. Brief Intervention sessions may take place the same day as the full screening or in subsequent days. In addition, all three brief interventions may be performed on the same day (30-45 minutes). Services are reimbursable using Healthcare Common Procedure Coding System (HCPCS) codes. The following table provides a breakdown of the reimbursable services.
Table A: New Medi-Cal SBIRT Services

<table>
<thead>
<tr>
<th>Services</th>
<th>Service Description</th>
<th>HCPCS Code</th>
<th>Billable</th>
<th>Payer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Screening</td>
<td>One full screening per recipient per year, using an approved Medi-Cal screening instrument.</td>
<td>H0049</td>
<td>$24</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Brief Intervention</td>
<td>Up to three brief intervention sessions per recipient, per year. Each brief intervention service is one session per unit, for 15 minutes per unit.</td>
<td>H0050</td>
<td>$48</td>
<td>Medicaid</td>
</tr>
</tbody>
</table>

In addition, the costs of SBIRT services are reimbursable in Rural Health Clinics (RHCs) and Federally Qualified Health Clinics (FQHCs), as long as they meet the definition of a RHC/FQHC visit. As described in the Medi-Cal Billing and Policy manual, a “site visit” is defined as a face-to-face encounter between the client and the health professional. ¹

There are, however, few services that do not qualify for reimbursement. Since screening and brief intervention sessions apply to alcohol misuse, services related to illicit drug use are not reimbursable. Secondly, pre-screening questions² are not reimbursable under Medi-Cal. Beginning April 2014, primary care providers must administer a Stay Healthy Assessment (SHA) that serves to identify and track patients’ high-risk behaviors. This age-appropriate questionnaire contains a single, pre-screen question on alcohol misuse. Since the alcohol pre-screen question is a part of routine care, providers are unable to receive separate reimbursement.

**Provider Restrictions**

With the new benefit, states have the flexibility to determine who is eligible to provide and bill for SBIRT services. In California, primary care providers must meet several requirements to administer the benefit. First, SBIRT services must be provided by a licensed provider, or by a staff member under the supervision of a licensed provider. Eligible licensed providers include: licensed physicians, physician assistants, nurse practitioners, and psychologists. Secondly, all licensed health care providers must receive at least four hours of certified SBIRT training. Thirdly, all non-licensed providers, in addition to being under the supervision of a licensed provider, must be trained to provide SBIRT services. Specifically, they are required to complete a minimum of 60 documented hours of professional experience and a minimum of 30 documented hours of face-to-face recipient contact. Lastly, providers are required to develop and implement policies and procedures that document the successful completion of SBIRT training by relevant staff members and physicians.

² Pre-screens are short-form questionnaires that are designed to assess one’s health. Based on the result, the physician may provide a full screen, which does have a separate billing code.
Challenges to Implementation of SBIRT and Work Flow Issues

Although SBIRT has proven to be effective in addressing alcohol-related substance use issues in adults, there are challenges related to its broad implementation. With the availability of alcohol screenings in the primary care settings, experts anticipate seeing an increase in demand for brief intervention and treatment services. There is some concern that an increase in need for these services without attention on how to seamlessly integrate them into practice may create an undue burden on staff in the primary care setting. Moreover, the additional time to administer the screening and/or brief intervention may cut into the patients’ already short visit. To ease the workflow, trained, unlicensed professionals, such as health educators that meet the eligibility criteria are authorized to provide SBIRT services in a primary setting. However, it is unlikely that simply adding additional staff will streamline the process without investing in practical strategies to integrate the new practice into the setting’s workflow. Moreover, primary care settings often do not have staff members who have received training on the risks for, and consequences of, substance use disorders, or on how to provide a screening and interpret the results in order to determine the appropriate response.

To address this challenge, the California Department of Health Care Services, in partnership with experts at UCLA and L.A. Care Health Plan, is facilitating a series of online trainings and webinars to educate clinicians on these services. These trainings serve to provide professionals with an understanding of the key SBIRT concepts, as well as guidance on how to administer the screening tool and brief intervention. Moreover, DHCS offers a wealth of resources and information on their website, such as screening instruments, consent forms, and fact sheets.

Why Did California Not Extend the Medi-Cal SBIRT Benefit to Youth Beneficiaries?

According to the Department of Health Care Services, Medi-Cal covers and provides reimbursement for all preventative services assigned a grade of “A” or “B” by the U.S. Preventive Services Task Force (the Task Force). The Task Force is an independent panel comprised of primary care and prevention experts responsible for reviewing the effectiveness of prevention services and developing recommendations based on available evidence-based research. The letter grading is based on the quality and strength of evidence to assess the risks and benefits of interventions. Interventions provided a grade of “A” or “B” are recommended for implementation, while an “I statement” issued by the Task Force indicates that there is not enough information to determine the effectiveness of the intervention.

In May 2013, the Task Force released its final recommendation statement on Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse. In this statement, the Task Force made two conclusions:
1) Health care professionals should ask adults about their drinking habits and provide brief counseling to those who screen positive to risky or hazardous alcohol behavior (B Recommendation), and

2) There is not enough evidence to conclude whether alcohol screening and brief intervention for adolescents, aged 12 to 17 years old, is effective (I Statement).

According to the Task Force, the evidence showed that screening and behavioral counseling interventions are effective in reducing alcohol misuse for adults. Conversely, the Task Force determined that there is not an efficient amount of research on the benefits and risks to make a recommendation for this type of intervention for adolescents, thereby resulting in an “I Statement.”iii This is not to say that the intervention is harmful or not recommended. In fact, part of the Task Force’s final statement recognizes that, “alcohol misuse among adolescents is an important public health problem. Limited evidence is available to assess the effects of screening and behavioral counseling in adolescents and high-quality studies specifically addressing this population is needed.”9

Is Screening and Brief Intervention for Substance Use Covered under Medi-Cal EPSDT Program?

Aligned with the recommendation of the U.S. Preventative Task Forces, California established a separate Medi-Cal reimbursement code and billing policy for SBIRT for adults. Eligibility for the benefit does not extend to adolescents under the age of 18. Screening for substance use disorders in adolescents, however, is covered under Medicaid’s child health prevention benefit known as Early and Periodic Screening, Diagnosis and Treatment (EPSDT).

EPSDT is a comprehensive and preventative child health benefit that serves to improve the growth and development of Medicaid beneficiaries under the age of 21. The prevention and early identification of health problems, including mental health and substance use disorders, is a key component of EPSDT. According to the Centers for Medicare and Medicaid Services, eligible beneficiaries must receive periodic screenings under the EPSDT benefit, including a health and developmental history assessment.10 Within this assessment, the physician is required to

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iiiThe USPSTF finding is based on a systematic evidence review of randomized, controlled trials and nonrandomized trials with controls or comparators published between 1985 and 2011 on screening and behavioral counseling interventions for alcohol misuse in adults, adolescents, and pregnant women. According to the USPSTF, none of the identified systematic reviews provided information about the use of screening tests in adolescents and no studies meeting inclusion criteria were identified for the effects of brief behavioral counseling interventions on screening-detected alcohol misuse in adolescents.
administer an age appropriate mental health and substance use health screening.\textsuperscript{iv}\textsuperscript{11} If the screening results are positive, the provider is responsible for conducting an assessment, and if necessary, providing the appropriate level of treatment.\textsuperscript{12}

Whether or not brief intervention sessions can specifically be provided and covered under the EPSDT benefit in California is not fully understood based on available information. Under federal law, children are entitled to receive the full scope of benefits within a state’s Medicaid program. They are also entitled to acquire additional services and treatments that are deemed medically necessary to correct or ameliorate a physical and/or mental condition, regardless of whether or not these services are offered under the state’s plan. Under the Medi-Cal program, brief intervention is limited to beneficiaries over the age of 18. Yet, under the EPSDT medically necessary concept, it may be feasible to receive this intervention. Further research and analysis is needed to better understand California’s interpretation of the medically necessary concept and the potential to deliver brief intervention services under the EPSDT benefit.

**Medicaid SBIRT Benefit in Other States**

Prior to the implementation of the ACA, the majority of funding for SBIRT services derived from grants distributed by SAMHSA. The time restrictions on grants, along with challenges to achieving reimbursement through governmental funding streams such as Medicaid, have made it difficult to integrate and sustain SBIRT in primary care providers.\textsuperscript{13} Research suggests that a promising approach to SBIRT sustainability is activation and utilization of Medicaid codes to allow for reimbursement of screening and brief intervention.\textsuperscript{14} In addition to sustainability, SBIRT proponents note the importance of establishing a separate Medicaid billing and coding policy to strengthen the implementation and practice of SBIRT.\textsuperscript{15}

With the incentive funding provided by ACA, some states established Medicaid reimbursement codes to cover screening and brief intervention for alcohol use with adults. Several states have extended the benefit to include Medicaid beneficiaries under the age of 18. Below are a few states that offer SBIRT with adolescents under Medicaid.

- **Washington.** Effective January 2014, Washington state Medicaid policy covers SBIRT for alcohol and illicit substances. SBIRT services may be provided in various medical and community healthcare settings, such as primary care centers, hospital emergency rooms, and trauma centers. SBIRT screening occurs during the adolescent’s well-child exam, and therefore, is not billable with a separate code. Brief interventions may be provided and billed on the same day as the full screen. Patients are limited to four brief

\textsuperscript{iv} Based on conversations with the Mental Health Association of California, the screening tool used in California to identify substance use and abuse is comprised of one “yes” or “no” question. It is questionable whether or not this one question screen is an adequate tool for the identification substance use problems.

- **New York.** New York Medicaid program reimburses for SBIRT services for all Medicaid beneficiaries who are 10 years of age and older.\(^{16}\) SBIRT services are provided in a variety of settings, which include hospital outpatient and emergency departments as well as School-Based Health Centers. SBIRT screening and brief intervention is billable to Medicaid using the Healthcare Common Procedure Codes System (HCPCS). Under Medicaid Fee-For-Service, two screenings and six brief intervention sessions are reimbursable per year. Under Medicaid Managed Care, two screenings and six brief interventions per year are reimbursable, and if found medically necessary, more than two SBIRT screenings may be provided. Information on the New York Medicaid SBIRT services can be found on the New York Department of Health here: [http://www.health.ny.gov/health_care/medicaid/program/update/2011/2011-06.htm#eme](http://www.health.ny.gov/health_care/medicaid/program/update/2011/2011-06.htm#eme). The National Academy for State Health Policy provides an overview of the behavioral health services offered to children and youth in Medicaid. [http://www.nashp.org/behavioral-health-medicaid-benefit-children-and-adolescents/new-york](http://www.nashp.org/behavioral-health-medicaid-benefit-children-and-adolescents/new-york)

- **Oregon.** Beginning January 2014, SBIRT is a covered benefit for all Medicaid beneficiaries in Oregon, age 10 and older. SBIRT is to be provided in the primary care and outpatient settings. Screenings are to be provided based on medical appropriateness, which is generally one screen per calendar year. The screening and brief intervention targets substance use, with the expectation of smoking and tobacco. A comprehensive overview of the program, including its background, eligibility, and billing policy, can be found in the Oregon’s SBIRT Guidance report here: [http://www.oregon.gov/oha/CCOData/SBIRT%20Guidance%20Document%20-%20Revised%20September%202013.pdf](http://www.oregon.gov/oha/CCOData/SBIRT%20Guidance%20Document%20-%20Revised%20September%202013.pdf).
Additional Resources

- California Department of Alcohol & Drug Programs. Affordable Care Act Requirements for Substance Use Disorder Services. This report provides an overview of the provisions in the ACA on substance use disorder services, and its implications for Medi-Cal recipients. [http://www.adp.ca.gov/healthcare/pdf/HCR_Overview.pdf](http://www.adp.ca.gov/healthcare/pdf/HCR_Overview.pdf)


- EPSDT: Resources to Improve Medicaid for Children and Adolescents. The Academy for State Health Policy generated a resource page that provides information on states’ EPSDT programs, as well as information on states’ approaches to behavioral health care and screening. [http://www.nashp.org/epsdt/resources-improve-medicaid-children-and-adolescents](http://www.nashp.org/epsdt/resources-improve-medicaid-children-and-adolescents)


- DHCS Stakeholder Engagement Meeting: Update on SBIRT Implementation. Generated by DHCS, this power point discusses the current implementation stage of the SBIRT services as well as next steps. [http://www.dhcs.ca.gov/provgovpart/Documents/DHCS%20SBIRT.pdf](http://www.dhcs.ca.gov/provgovpart/Documents/DHCS%20SBIRT.pdf)

- DHCS: SBIRT Main Webpage. This site provides an overview of the new SBIRT services, and available resources, from screening and brief intervention tools, to trainings. [http://www.dhcs.ca.gov/services/medi-cal/Pages/SBIRT.aspx](http://www.dhcs.ca.gov/services/medi-cal/Pages/SBIRT.aspx)

- The Health Resources and Services Administration. EPSDT Overview. This site provides an overview of the EPSDT program, including EPSDT program background and requirements. [http://www.mchb.hrsa.gov/epsdt/overview.html](http://www.mchb.hrsa.gov/epsdt/overview.html)


- The Affordable Care Act’s Prevention and Public Health Fund in California. Authorized under the ACA, the Department of Health and Human Services awards grant that funds prevention activities. This site provides a breakdown of the different activities the fund has awarded in California. [http://www.hhs.gov/healthcare/facts/bystate/publichealth/ca.html](http://www.hhs.gov/healthcare/facts/bystate/publichealth/ca.html)
Ending Chronic Homelessness

Since 1990, the Conrad N. Hilton Foundation has been dedicated to ending chronic homelessness in Los Angeles County. The Foundation recognizes that “housing first” is the most effective approach to addressing homelessness. Consequently, the Foundation works to enhance permanent supportive housing resources so former chronically homeless persons can receive the wraparound services they need to achieve housing stability, self-sufficiency, and optimal health outcomes. Over the last several months, the Foundation has been providing grants to increase access to health care services for persons experiencing homelessness in an effort to strengthen housing retention.

Various provisions outlined in the Affordable Care Act (ACA) aim to improve the health outcomes and quality of life of persons experiencing homelessness. The Foundation was interested in learning about how changes to the Medi-Cal program will improve access to care as well as increase the scope of mental health and substance use treatment services. In addition, the Foundation is interested in understanding opportunities to enhance care coordination between the primary care setting and behavioral health care services.

This section discusses a myriad of opportunities to improve the health outcomes of persons experiencing chronic homelessness and individuals in supportive housing. It also highlights barriers to implementation, including enrollment into Medi-Cal coverage and Medi-Cal managed care. In addition, it discusses promising practices to overcome enrollment barriers facing the homeless population.

ACA: Opportunities to Prevent and End Chronic Homelessness

Persons experiencing chronic homelessness often have chronic and complex health problems. At the same time, they face various barriers to accessing affordable, quality care. Some of these barriers include unemployment, poverty, substance use disorders, and mental health and/or cognitive challenges. Without health care coverage, chronic homeless persons face challenges in accessing consistent medical care, including preventive services. Consequently, chronically homeless people are at greater risk of acquiring and/or exacerbating a chronic condition or disease. Moreover, the population uses higher rates of hospitalization and emergency room visits than the general population, resulting in significant health care costs to the public system. According to the California Department of Health Care Services, the annual cost for inpatient care for persons experiencing homelessness in Los Angeles County is $70 million.17

The Affordable Care Act (ACA), however, is considered to be a significant piece of legislation in the movement to prevent and end chronic homelessness. The ACA is expected to improve the health outcomes and quality of life of persons experiencing homelessness in three significant
ways: 1) it increases access to affordable health care coverage, 2) it expands and improves the breadth and scope of health services available, including behavioral health care, and 3) it has the potential to enhance the delivery and coordination of services, with a particular emphasis on patient-centered care.\textsuperscript{18}

This section considers the implications of the ACA for persons experiencing chronic homelessness and individuals in supportive housing. First, it discusses expanded Medi-Cal eligibility as a result of the Medicaid Expansion Option. Second, it examines the expansion of mental health and substance use disorder services under Medi-Cal. Lastly, it highlights opportunities to enhance integrated care and care coordination for persons experiencing homelessness, such as the Medicaid Health Home Option.

**Expand Eligibility**

Historically, persons experiencing homelessness have faced challenges in enrolling into Medicaid due to eligibility requirements. State Medicaid plans required individuals to meet an income threshold as well as fit under a specific eligibility group, such as a person with disabilities who are eligible for Supplemental Security Income or those with dependent children. Consequently, some childless, homeless adults have been excluded from the program.

The ACA, however, provides an opportunity to extend Medicaid coverage to the vast majority of persons experiencing homelessness. Commonly referred to as the Medicaid Expansion Option, this provision extends eligibility to childless adults, between the ages of 19 and 64, who have an income up to 138\% of the federal poverty level.\textsuperscript{19} For a single adult, that is an annual income of $15,856. States that opt-in to the program qualify to receive a federal match grant for services of 100\% from 2014 to 2016, gradually reducing thereafter.

California is one of the 26 states that have opted to expand its Medicaid program (Medi-Cal), beginning January 2014. With the expanded eligibility, an anticipated 1.4 million additional Californians will be enrolled into Medi-Cal by 2016.\textsuperscript{20} Of the 1.4 million, an estimated 55,000 are persons who are chronically homeless.\textsuperscript{21}

There are various potential benefits of extending eligibility to individuals experiencing homelessness. First, more homeless persons and supportive housing tenants will be able to gain access to the treatment and care they need to improve health outcomes. For instance, the Medi-Cal program covers many of the mental health and substance use treatment services needed by this population.\textsuperscript{22} Secondly, Medi-Cal coverage allows the homeless population to receive routine care by a primary care physician, and therefore, could reduce reliance on costly emergency room use and hospitalization.\textsuperscript{23} Lastly, the expansion makes funding more stable for providers serving the homeless population. Providers can expect to see a reduction in uncompensated care costs, and an increase in reimbursement for some Medi-Cal services.\textsuperscript{24}
Consequently, providers and clinics will be able to treat more people, as they will not have to absorb the costs of treatment.

**Expansion of Mental Health and Substance Use Disorder Services**

According to the Substance Abuse and Mental Health Services Administration, an estimated 30% of chronically homeless persons have mental health conditions, and approximately 50% have co-occurring substance use problems. Health care reform provided an opportunity to expand and improve care for people with one or both of these disorders. The ACA mandates that all health insurance plans include mental health and substance use disorder services as one of the ten essential health benefits. In addition, the ACA builds on the Mental Health Parity and Addiction Equity Act of 2008 by ensuring coverage of mental health and substance use disorder services is comparable to coverage of medical and surgical care. Consequently, California adopted an essential benefits package that expands the scope and range of mental health and substance use disorders services for Californian residents, including chronically homeless persons and individuals in supportive housing.

Effective January 2014, qualified Medi-Cal recipients who require mental health treatment, but do not have a serious mental illness, may receive expanded mental health benefits through Medi-Cal Managed Care, or Fee-For Service for those not enrolled in a managed care plan. New mental health services for those with non-serious mental illness include: psychotherapy, psychiatric consultation, psychological testing (when clinically indicated to evaluate a mental health condition), outpatient services for the purposes of monitoring drug therapy, inpatient services, and outpatient laboratory, drugs, supplies and supplements. To qualify for these services, the Medi-Cal beneficiary must meet the medical necessity criteria. Those who are diagnosed with a severe mental health illness will continue to receive specialty mental health services through the county mental health plans.

Expanded substance use disorder services are also available to Medi-Cal beneficiaries effective January 2014. Historically, services have been limited to children under the age of 21 and/or pregnant and postpartum women. Under California’s adoption of Medicaid Expansion, eligible Medi-Cal beneficiaries, regardless of age or categorical group, may receive expanded substance use disorder services through the county-administered Drug Medi-Cal program. Expanded substance use disorder services include: intensive outpatient treatment, residentially-based substance use disorder services, and medically necessary inpatient detoxification.

**Enhanced Integrated Service Delivery**

Integrated care—referred to as the delivery of comprehensive health care services—is an approach characterized by collaboration, information sharing, and coordination. Evidence shows that integrated systems of care is the most effective approach to providing supports and services for persons with complex, special health care needs, including chronically homeless persons and
individuals in supportive housing. The ACA embraces the concept of integrated care, providing opportunities to enhance the delivery of integrated, coordinated care to better meet the health needs of persons with complex, chronic conditions. This section highlights initiatives spearheaded by California to enhance the integration of its service delivery across multiple systems, including behavioral health care.

**Medicaid Health Homes Option**

One of the achievements of the ACA is the Medicaid Health Homes Option. Under the philosophy of the “whole person” approach, the goal of the health home model is to enhance access to and coordination of primary care, behavioral health care, and long-term services and supports for persons with chronic conditions. This option has attracted significant interest from states that are interested in improving care delivery in Medicaid. States that decide to take advantage of the option will receive a 90% enhanced federal match for specific health home services during the first two years of implementation.

With the health home option, states have the flexibility to design the program to address an array of policy goals and issues. In October 2013, Governor Brown signed Assembly Bill 361, which authorized the development and implementation of the health home model. If the state decides to follow through with this option, the legislation requires the state to target frequent hospital users with chronic conditions and individuals who are chronically homeless. The goal is to reduce health care costs and augment health outcomes for these underserved populations.

States also have the flexibility to determine eligible providers. Health home programs may be administered by one designated provider, such as community health center or physician, or by an interdisciplinary team of health professionals. The health team may include: physicians, nurse care coordinators, nutritionists, social workers, and behavioral health professionals. These health teams are not required to provide services under the same roof. Services may be situated in a freestanding, virtual, hospital-based, or a community mental health center. These teams are required, however, to provide core services to patients and to coordinate services needed to access and maintain health stability.

To qualify as a health home provider, the provider or team must partner with, and provide linkages to, social service providers, which include housing navigators and housing providers. Research shows that connections to housing with wraparound services are vital to improving health outcomes of persons who are chronically homeless as well as reducing health care utilization and costs. In addition, some of the services mandated under the health home option are similar to the services and supports provided by supportive housing providers, such as intensive care management and rehabilitation. Thus, supportive housing providers could be instrumental in delivering key health home services. This could also provide an opportunity for supportive housing providers to receive reimbursement for services already provided, but are
generally more difficult to cover under Medi-Cal. Currently, Medicaid does not cover all permanent supportive housing services.

The health home option also offers the opportunity to create behavioral health homes for persons with serious mental health or substance use disorders. These behavioral health homes are not required to provide the full array of medical services, as long as they ensure the availability and coordination of these services. As a result, behavioral health agencies are encouraged to build local partnerships to ensure clients are able to access the full scope of services they may need.

At the moment, there is no deadline for the design and implementation of a Health Home program in California. The CA Department of Health Care Services secured a grant from the federal government to design the program, which includes establishing a list of qualified services, designating providers, selecting geographic areas, and more. Once the program design is established, the department is authorized to submit a state plan amendment to the Centers for Medicare and Medicaid Services for consideration. This process may take several years to establish.

**Enhance Capacity of Community Health Clinics**

Community Health Clinics (CHCs) are an essential piece to providing comprehensive, culturally appropriate care for vulnerable populations. These health clinics place an emphasis on medical homes, coordinated primary care and preventive services. Outside of primary care services, many CHCs provide mental health and substance use disorder treatment services on-site. Those that are not working to formally integrate their primary care and behavioral health programs are legally required to connect clients to these appropriate services.

Recognizing the importance of CHCs at providing integrated, coordinated health care to vulnerable populations, the federal Department of Health and Human Services (DHHS) has been dispersing grants under the ACA to strengthen the capacity of CHCs in California and across the United States. In November 2013, approximately 46 CHCs throughout California received funding from the DHHS in the amount of $30.6 million to establish new health care delivery sites. An estimated 333,000 additional Californians will receive care from these new delivery sites.

In addition to the expansion of delivery sites, DHHS announced that it would award grants to CHCs to help them establish or expand behavioral health services. This funding stream provides an opportunity for CHCs to hire new mental health and substance use disorder professionals, or establish team-based models of care. Funding may also be used to add mental health and substance use disorder services. Ultimately, these grants will help to integrate behavioral health care into the primary care setting.
Service Delivery and Payment Reform: Realignment of Drug Medi-Cal

In light of the state’s recent health care reforms, DHCS is currently applying for a waiver with the Center for Medicare and Medicaid Services to operate the Drug Medi-Cal program as an organized delivery system. The structure would build upon the existing county-administered specialty mental health program. This type of model serves to enhance the integration and coordination of substance disorder use services across primary care and mental health systems, as well as increase the monitoring of provider delivery of services to Drug Medi-Cal beneficiaries. Moreover, the realignment would serve to enhance the integrity of the program and help prevent provider fraud and misuse of public funds. Specifically, it would strengthen county oversight of network adequacy, service access, and standardized practices in provider section.

ACA Implementation Challenges for People Experiencing Chronic Homelessness

The ACA provides ample opportunities to strengthen access to quality care for persons experiencing chronic homelessness. However, there are still challenges related to enrollment and delivery of care. This section provides an overview of these challenges.

Enrollment Barriers

While the state of California is making headway in enrolling under-resourced populations into the Medi-Cal coverage, including persons experiencing chronic homelessness, there are still barriers to enrollment for people who are chronically homeless. Common enrollment barriers are: lack of awareness of Medi-Cal eligibility, distrust from the homeless population, confusion around the enrollment process, and missing appropriate documentation.

Lack of Awareness of Medi-Cal Eligibility

Community health clinics, community-based organizations and advocates have made headway in spreading awareness about Medi-Cal Expansion and enrolling homeless persons into the program. However, there are still many homeless persons who are unaware that they qualify for Medi-Cal Extension. Some persons experiencing homelessness have little to none interaction with community health clinics. In addition, others do not understand the potential benefits of obtaining Medi-Cal coverage.

Distrust of and Disengagement from Public Systems

Although Medi-Cal provides a pathway to receiving quality health care, many persons experiencing homelessness are seeking medical attention through community health clinics. Many persons experiencing homelessness are utilizing these clinics because they prefer to receive care within their community, and do not feel comfortable receiving care within traditional medical settings. In addition, many homeless persons are disengaged from and distrustful of public systems. Many chronic homeless persons have reported negative experiences
with public and health care systems in the past; therefore, some are reluctant to apply for assistance.40

Confusion Around Enrollment Process
Frontline workers noted that some chronically homeless persons have trouble understanding the enrollment process.41 The information required, along with the application instructions, can be confusing for the applicant, especially for those with mental health challenges or cognitive delays. Thus, the application process has discouraged many chronically homeless individuals from applying.

Missing Appropriate Documentation
Lack of documentation also serves as a major barrier to enrollment for persons experiencing chronic homelessness.42 The Medi-Cal enrollment process requires applicants to provide some form of identification such as a birth certificate, driver’s license or social security card. Without this information, the applicant may not be able to complete the Medi-Cal application, or receive a wrongful determination of eligibility. Chronically homeless persons tend to face challenges in providing this information. Lacking a safe place to store documentation, these items are highly susceptible to loss and theft. As a result, persons experiencing chronic homelessness must seek additional assistance from an enrollment worker to retrieve these documents. This, in turn, delays the enrollment process and requires additional time and resources on the providers’ end to successfully enroll the applicant.

Expanded Substance Use Disorder Services and Provider Capacity Challenges
Due to the Medi-Cal Expansion, integration of alcohol screening in the primary care setting, and the expanded substance use disorder benefits through Drug Medi-Cal, county officials, including Los Angeles County, predict that there will be a significant increase in demand for substance use disorder treatment services.43 In Los Angeles alone, there are currently 242,000 eligible people who need substance use disorder services. Under the ACA, an estimated 64,000 additional persons will be eligible for these services.

With the increase in access to services, there is great concern that the workforce is insufficient in size to meet the expected demand for services.44 As of now, there is a shortage of certified Drug Medi-Cal providers. There are many small licensed clinics that are interested in becoming Drug Medi-Cal certified; however, they do not meet the requirements, or experience delays in getting certified by the state due to a backlog in the system.45 Moreover, there is a concern about a shortage of substance use disorder personnel who are adequately trained to work with chronically homeless persons with high needs. In addition, low Medi-Cal reimbursement rates stand as a barrier to increasing capacity. Under federal regulations, for example, residential treatment centers can only receive reimbursement for 16 or fewer beds.46
Achieving a Robust, Integrated Delivery System Barriers

According to Mitchell Katz, the Director of the Los Angeles County Department of Health Services (DHS), a major challenge that lies ahead in the health care reform movement is the development of a robust service delivery system. In his expert opinion, Los Angeles County and others will be successful in enrolling eligible participants into an appropriate health care insurance plan, including Medi-Cal. Yet, in his words, “health insurance is not health care…. it does not necessarily allow you to gain access to care.”47 Therefore, there is a need to build a robust integrated delivery system that ensures clients are able to connect to the right provider and receive the appropriate level of care.

There have been significant strides to create an integrated system of care in Los Angeles County and California; yet, some chronically homeless persons and individuals in supportive housing may experience challenges in connecting to the correct provider.48 Under the Medi-Cal Expansion, newly eligible persons must select a Medi-Cal managed care plan and primary care provider 60 days after enrolling into Medi-Cal. If not, applicants are automatically assigned to a plan. Some individuals who were automatically assigned have found themselves seeking care from providers that lie outside of their network. This, in turn, can create disruptions in care coordination from providers that offer homeless services, such as a mental health clinic and supportive housing building.49

Potential Challenges with the Reduction of County Funds for Indigent Health Care

In 2013, California Governor Jerry Brown presented two approaches for the implementation of the Medical-Expansion: 1) a county-based option that places the fiscal and programmatic responsibility for the provision of health care services on counties, or 2) a state-based option that builds on the Medi-Cal managed care program. In the end, the state elected the state-based option. Under the state-based Medi-Cal Expansion program, state officials expect the county costs and responsibilities to the indigent health program to decrease as more uninsured, low-income persons gain coverage.50 Due to expected county savings, county realignment funds will be reduced by 60 percent based on anticipated indigent health care savings from the expansion.51

The reduction in funds for indigent health care raises concerns among homelessness stakeholders and providers. According to a recent report generated by the Conrad N. Hilton Foundation’s third-party evaluator, Abt Associates, the reduction in funding may result in fewer resources to initiatives that support supportive housing services, including services that are not reimbursable under Medi-Cal.52 A study conducted by the Health Access Foundation in November 2013 also highlights the real possibility of county consumers having access to less care and services, depending on the decisions made at the county level.53 Although many will gain access to health
care coverage, the Health Access Foundation expresses the need to maintain a robust safety net and indigent care system for those who will remain uninsured.

**Medicaid Health Homes Option and Implementation Challenges**

California is one of the 21 states that have an approved state plan amendment to establish the Medicaid Health Home model. This model creates a dramatic way to integrate and coordinate care for persons with chronic conditions, including persons experiencing homelessness. As the state begins to design this model of care, there are several concerns that deserve attention.

**Question of Financial Sustainability**

As authorized under the Affordable Care Act, the California Health Home program will be 90% funded by federal funding for two years. The non-federal share of costs will be covered by philanthropic giving for the first two years; thereafter the federal share of costs will reduce California’s federal funding rates, which has been historically 50%. The Centers for Medicare and Medicaid Services is considering allowing higher federal funding rates for the Medi-Cal Expansion population, which would be 100% until 2017. Following 2017, the on-going federal matching rate would fall to 90% (or higher) for the expansion population. For Medi-Cal beneficiaries who are categorically eligible, matching funds could come from funds from Proposition 63, and existing county investment in frequent hospital user and supportive housing programs. Yet, questions remain on how the health home option will remain financially sustainable after the two-year mark when the federal match rate reduces.

**Labor Intensive**

States that have the health home model up and running noted that the implementation process is complicated and labor intensive. States have encountered problems with facilitating communication between different sectors of the health system, encouraging health home participants to use new technology to foster information sharing, and educating providers about the program’s purpose.

**Promising Practices to Overcome Enrollment Barriers**

There are several effective outreach and enrollment strategies that can be used for persons experiencing homelessness. The following strategies have been devised from lessons learned from the early ACA enrollment and implementation efforts undertaken in California and other states, including Illinois and Colorado. It also includes feedback and insight from advocates, stakeholders, government officials, and social service providers. These outreach and enrollment

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\^ Also referred to as the Mental Health Services Act, this Act authorized a tax on incomes over $1 million to fund new county mental health programs.
strategies should be encouraged to be utilized by organizations and agencies in Los Angeles County and throughout California.

- **Increase Staff Capacity to Maximize Enrollment.** Barriers, such as lack of documentation, illiteracy and mental health conditions, can stand in the way of enrolling into Medi-Cal. With increased staff capacity, organizations are better equipped to work with this population and enroll them into Medi-Cal. A number of roles have been established over the last year related to enrollment that agencies and community organizations can take advantage of. Community health clinics, for instance, were awarded federal Outreach and Enrollment Assistance grants to hire additional workers to enroll uninsured populations into the health exchange plans and Medi-Cal. In addition, DHCS established the Medi-Cal Enrollment Assistance program, which serves to maximize enrollment into Medi-Cal by providing Certified Enrollment Counselors (CECs) and Certified Insurance Agents (CIAs) an enrollment assistance payment of $58 for each approved Medi-Cal application.\(^{55}\) These positions tend to be held at licensed health care clinics, community-based organizations, and faith-based organizations.

- **Provide One-On-One Assistance.** One of the most effective strategies is to provide one-on-one assistance through the application and enrollment process.\(^{56}\) In a private setting, eligible applicants are more likely to feel comfortable sharing personal information, such as income eligibility and affordability concerns. Moreover, it provides an opportunity for the frontline worker to help the applicant fill out the application, obtain appropriate documentation, and trouble shoot enrollment challenges. This, in turn, increases the likelihood of the applicant enrolling into the program.

- **Establish Partnerships with Community-Based Organizations and Social Service Providers.** Community Health Clinics are in regular contact with uninsured and/or persons with low-incomes, which includes the chronically homeless population. This provides health professionals a unique opportunity to educate patients on the Medi-Cal program, as well as facilitate the enrollment process. Yet, frontline staff at these clinics has noted that it can be challenging to reach and follow-up with patients outside of the clinic. Partnerships with community-based groups and social services providers, such as homeless shelters, churches, food kitchens, and food pantries, are instrumental to reaching populations that are more difficult to contact and may need additional engagement.

- **Conduct Grassroots Outreach and Enrollment.** According to advocates, the majority of outreach and enrollment efforts targeted at the homeless population will take place at the grassroots level.\(^{57}\) Many persons experiencing homelessness are highly mobile and lack a permanent mailing address. In addition, some are fearful and distrustful of health care providers, and therefore, may have little contact with community health clinics.
Meeting homeless persons where they are—the streets, in the park, at shelters among others—is important to successfully educating and enrolling this population into Medi-Cal.\textsuperscript{58}

- **Gradual and Targeted Relationship Building.** Some homeless persons are reluctant to enroll into Medi-Cal program due to a lack of trust in public systems. Relationship building and engagement can help this population overcome issues of distrust and disengagement. Addressing the immediate needs of the applicant, such as providing bus passes, socks, etc., can help establish trust.\textsuperscript{59} The process of building and establishing trust may take weeks or even years to accomplish.
Additional Resources


- **Medi-Cal Eligibility and Enrollment Tips for Providers of Homeless Assistance and Supportive Housing.** The California Department of Health Care Services and the Department of Community Development generated an eligibility and enrollment tip sheet for providers of homeless assistance and supportive housing to help their clients gain access to health care coverage. [http://hcd.ca.gov/lets_get_everyone_covered0314.pdf](http://hcd.ca.gov/lets_get_everyone_covered0314.pdf)


- **California Mental Health Services Authority. Integrated Behavioral Health Project.** This site provides a wealth of resources and information designed to integrate delivery of primary and behavioral health care in California. [http://www.ibhp.org](http://www.ibhp.org)


- **National Academy for State Health Policy. “Developing and Implementing the Section 2703 Health Home State Option: State Strategies to Address Key Issues”** (2012) This publication describes five issues that states are likely to face during the development and implementation of the health home model, which includes finance and payment, and sharing health data. [http://www.nashp.org/sites/default/files/health.home_state_option.strategies.section.2703.pdf](http://www.nashp.org/sites/default/files/health.home_state_option.strategies.section.2703.pdf)

- **Kaiser Family Foundation. Medicaid Health Home Beneficiaries with Chronic Conditions.** (Aug. 2012) This publication provides an overview of the direction of the health home initiatives, and challenges to establishing the program. [http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8340.pdf](http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8340.pdf)

- **California Improvement Network. “Health Homes: Perspective from the Leaders.”** (Feb. 2014). This power point provides an overview of the health home model, challenges in implementing the program, and strategies for overcoming them. It also highlights the successes of the health home program in Washington. [http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDFs/PDF%20Clinical%20webinar02262014HealthHomes.pdf](http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDFs/PDF%20Clinical%20webinar02262014HealthHomes.pdf). Here is also the webinar to accompany the PDF file. [http://www.chcf.org/events/2014/cin-webinar-02-26-2014](http://www.chcf.org/events/2014/cin-webinar-02-26-2014)

- **Evaluation of the Medicaid Health Home Option—Base Year.** This report, generated by ASPE, examines the health home model, challenges and emerging issues with its implementation, and a profile of four states. [http://aspe.hhs.gov/daltcp/reports/2012/HHOption.shtml#implement](http://aspe.hhs.gov/daltcp/reports/2012/HHOption.shtml#implement)

- **California AB 361 Bill Analysis.** This policy brief provides a detailed description of AB 361 (Medi-Cal Health Home Bill) and an analysis of its fiscal implications. [http://www.leginfo.ca.gov/pub/13-14/bill/asm/ab_0351-0400/ab_361_cfa_20130812_101700_sen_comm.html](http://www.leginfo.ca.gov/pub/13-14/bill/asm/ab_0351-0400/ab_361_cfa_20130812_101700_sen_comm.html)
Supporting Transition-Aged Youth in Foster Care

Since its inception, the Conrad N. Hilton Foundation’s Foster Youth Strategic Initiative has been working to improve the well-being and outcomes of older foster youth transiting out of care. The Foundation supports programs that enhance career and college readiness, provide services and training for caregivers of transition age foster youth, and support particularly vulnerable populations like pregnant and parenting youth or foster youth who have also touched the juvenile justice system. In addition, the Foundation supports efforts that strengthen collaboration and coordination across systems, organizations, and research to better inform policy and practice.

The most significant achievement for former foster youth under the Affordable Care Act is the extension of Medicaid eligibility to the age of 26. With the national health care reform movement, the Foundation was interested in understanding the protocols to identifying and enrolling former foster youth into the Medi-Cal extension program. Specifically, the Foundation was interested in understanding how former foster youth enroll into Medi-Cal, as well as who provides support in the application and enrollment process.

This section discusses the Medi-Cal extension provision and simplified redetermination process. It also highlights the challenges this population faces in enrolling into the Medi-Cal extension program. Moreover, it highlights promising practices to overcome barriers to enrollment.

ACA: Push Towards Access and Equity for Foster Youth

Studies demonstrate that former foster care youth face several barriers to accessing affordable, quality health care. Unlike their non-foster care peers, many former foster youth secure employment that does not provide health benefits. In addition, many do not have the option of obtaining coverage in a parent’s or guardian’s employer-based insurance, or receiving financial assistance to purchase health insurance. Countless studies also show that lack of health insurance is associated with poor health outcomes. Poor health and well-being can negatively influence educational achievement of former foster youth. Students with poor physical and/or mental health are more likely to miss school, perform poorly on tests, and drop out of school.

The Affordable Care Act serves to increase access to affordable health and mental health care coverage. Under the Act, former foster youth are covered through Medicaid until the age of 26. This parallels the provision that allows young adults to remain on their parents’ insurance plan to the age of 26. Moreover, the ACA mandates that states streamline the redetermination process for former foster youth in an effort to prevent discontinued coverage of care.
This section provides an overview of the extension of Medi-Cal coverage for former foster youth, including eligibility criteria, enrollment and verification process, and schedule of benefits, as well as describes the redetermination process.

**Expand Medi-Cal Coverage from Age 21 to 26**

As of January 2014, all states must extend Medicaid eligibility for foster youth to the age of 26, regardless of whether or not they participate in the Medicaid Expansion option. Previously, in the state of California, youth received coverage to the age of 21. This provision in the ACA recognizes the complex, special health care needs of this population, and the significance of the Medicaid program in addressing these needs. Moreover, it recognizes the importance of providing former foster youth with a stable source of coverage as they complete their academic studies and/or transition into the workforce. As a result of the extension, an estimated 26,000 former foster youth between the ages of 21 and 26 may qualify for Medi-Cal coverage.61

**Eligibility**

To qualify for Medi-Cal coverage, youth must have been under the care of the state, in California or in another state, on their 18th birthday.62 Youth must also be living in California and under the age of 26.63 Youth are not required to disclose financial information, as determination of eligibility is not based on an income or asset test. Therefore, youth may earn income without worrying about losing coverage.

Moreover, foster youth may qualify for coverage regardless of the foster care placement.64 This includes being placed with relatives or in a probation-supervised placement. As long as the young adult was in the foster care system at the age of 18, he or she qualifies for coverage. Youth who were in guardianship or adopted from foster care before the age of 18, however, do not qualify for this extension.

Although California state law extends Medi-Cal coverage to eligible youth who move from another state, other states are not required to extend coverage to out-of-state former foster youth. Youth that decide to move out of California may still be eligible for medical benefits, but will have to apply for these benefits in the new state of residence.65

**Enrollment Process for Former Foster Youth**

Under the ACA provision, youth who are emancipated from the foster care system after January 1, 2014, will automatically continue coverage until the age of 26, and therefore, are not required to fill out an application. However, young adults between the ages of 18 and 26 that are not currently enrolled in the Medi-Cal program must apply.

According to advocates, the best pathway for former foster youth to enroll into Medi-Cal is through county welfare departments.66 Former foster youth may apply in-person at the county
Medi-Cal office using a simple, one-page form known as a MC 250A. Upon completing the one-page form, the applicant is immediately enrolled into the program and provided an active Medi-Cal benefits number. The county worker is then responsible for verifying the former foster care status of the applicant. Ideally, the county enrollment worker would be able to verify the former foster care status of the youth before leaving the office.67

To ease the enrollment process, some counties have assigned a point person to assist former foster youth. These designated point persons may help the youth enroll into the program and/or identify streamlined ways for them to apply without having to go into the office.68

Verification Process for Former Foster Youth
Once the former foster youth is enrolled into the Medi-Cal program, the county must verify the former foster care status of the applicant. County workers have 30 days to verify the former foster care status with the county or state where the youth turned 18. The verification process varies depending on whether or not the youth was in the foster care system in California or another state.

For youth under the care of California, the Department of Health Care Services encourages county workers to verify the foster care status through the CA Department of Social Services’ Child Welfare System/Case Management (CWS/CMS) system.69 This system links all 58 counties and the state to a common database that tracks and records the case files of youth who were in the California Child Welfare System. If the county worker is unable to verify the status of the youth in the database, or does not have access to the database, he or she must contact the county where the youth aged-out to verify the status.

For out-of-state youth, it is recommended that youth provide documentation that verifies he or she was in foster care at the age of 18.70 If the youth isn’t able to provide any verification documents from a public agency, the county is required to contact the appropriate state to verify the status. If the county is unable to obtain verification within the 30-day allotted time, the county is required to determine whether or not the youth is eligible under another coverage group.

While the verification is pending, the county is responsible for enrolling the applicant into the Statewide Automated Welfare Systems (SAWS) under the former foster care coverage group (aid code 4M). The 4M aid code ensures that former foster youth are exempt from re-applying for coverage annually. As of now, SAWS is not programmed to automatically assign this code to former foster youth over the age of 21. As a result, the county worker must manually override the system to ensure the applicant is assigned the correct aid code. DHCS is currently working on this system issue and will be providing county workers with guidance on updated system changes in the near future.
**Schedule of Benefits Available**

Unlike the Medicaid expansion option, foster youth are eligible to receive coverage under Fee-For-Service (FFS)\textsuperscript{vi}, thereby allowing them to receive services and treatment at any provider that accepts Medi-Cal. Youth have the option of enrolling in a Managed Care Plan (MCP) if so desired. Under Medi-Cal FFS and MCP, youth are entitled to the full scope of Medi-Cal coverage at **no cost**. Instead of spending money on health care related costs, former youth can spend their income towards basic living essentials such as rent and food, as well as college related expenses.\textsuperscript{71} The Adult Medi-Cal program includes medical, vision, substance abuse treatment, dental (starting May 2014), and mental health coverage.

Youth under the age of 21 are able to receive additional services and supports under the California Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. Through EPSDT, youth have access to comprehensive screening, diagnostic and treatment services. Youth are entitled to receive the full scope of benefits covered under Medi-Cal. In addition to the Medi-Cal benefits, youth may receive additional treatment services that are determined to be medically necessary to correct or ameliorate a health condition.

**Simplified Redetermination Process**

Prior to the ACA, youth that aged out of the system on their 18\textsuperscript{th} birthday in the state of California were automatically continued coverage, without completing a formal application. Yet, to maintain coverage, former foster youth between the ages of 18 and 21 were required to go through an annual re-determination of eligibility. This required filling out a redetermination form that requested proof of residency. If the youth did not receive the redetermination notice, or failed to return the redetermination form after a certain period of time, Medi-Cal coverage was discontinued.

The ACA, however, requires states to develop and implement a simplified redetermination form for the program.\textsuperscript{72} In California, youth enrolled in the Medi-Cal program will receive uninterrupted care until the age of 26 and are not required to fill out an annual redetermination form to maintain coverage. Enrolled youth are required to fill out and return a simple redetermination form only if information known to DHCS or the county is no longer accurate or is materially incomplete.\textsuperscript{73} For example, if the data systems indicate that the youth may no longer be a state resident, the youth would be required to return a form to verify his or her residency.

To ensure continuous coverage, DHCS is awaiting federal approval to implement a renewal process that allows former foster youth to remain in the program in the event that the redetermination form is undelivered or the county is unable to establish contact.\textsuperscript{74} The youth

\textsuperscript{vi} Former foster youth who are already enrolled in a County Organized Health System will continue to receive coverage from this plan, instead of receiving services from Medi-Cal managed care or fee-for-service.
shall remain covered under Medi-Cal until the county determines ineligibility or re-establishes contact. Termination of Medi-Cal coverage can only be established if DHCS or the county finds evidence the youth is no longer eligible, provides advanced notice, and all due process requirements are met. This provision serves to reduce the number of terminations among former foster youth due to a loss of contact.

DHCS is still currently in the process of drafting policy guidance on the simplified redetermination form and process for county departments.

**Challenges to Medi-Cal Enrollment for Former Foster Youth**

The Medicaid extension under the ACA is a key provision for former foster youth. Those who are eligible for coverage can receive adequate care at no cost. In California, however, there have been hiccups in the road to enrolling former foster youth into the Medi-Cal program. These identification and enrollment barriers range from wrong determination of eligibility to incorrect dissemination of information from county workers, Covered California staff, and Health Care Options call center staff. This section provides an overview of the challenges faced by former foster youth in accessing Medi-Cal coverage over the last several months.

**Identification of Aged-Out Foster Youth**

Advocacy groups, outreach organizations and the like are finding it difficult to identify youth who have already aged out of the foster care system. The foster youth population tends to be highly mobile, often changing addresses or not having a permanent residence. After leaving the foster care system, they do not usually remain in touch with their former case and/or social worker. As a result, counties tend not to have the most up-to-date contact information for this population. Moreover, former foster youth are resistant to re-engage with the system and identify as former foster youth for fear of negative labeling. These circumstances present challenges in identifying and educating former foster youth on the Medi-Cal program, eligibility criteria, and its benefits, as well as enrolling this population into the program.

**Barriers to Enrollment**

Prior to the release of the CA Department of Health Care Services’ enrollment guidance letter on January 17, 2014, some eligibility workers at the county-level were unaware of the Medi-Cal extension benefit for former foster youth and/or its eligibility criteria. The lack of awareness at the county-level served as an enrollment barrier for former foster youth. As youth attempted to sign-up for the program or learn more about its benefits, enrollment workers would communicate incorrect information about the program. Other county workers, unaware of the existence of the program, were unable to provide guidance on how to enroll. Moreover, some eligibility workers
requested income/pay stubs to determine eligibility, although income and asset tests are waived for this population. This, in turn, has led to incorrect determinations of ineligibility.

Currently, Covered California does not provide a streamlined system for former foster youth to enroll into the Medi-Cal program. Through the online application, youth have experienced delays in receiving their benefits, as well as being incorrectly categorized into other coverage groups. Former foster youth are unable to circumvent unnecessary questions on the application form. In addition to the online application, the Covered CA phone system is not designed to screen and identify former foster youth. As a result, some former foster youth have been instructed to fill out the lengthy Medi-Cal application, which has led, at times, to an incorrect determination of eligibility.

Moreover, counties may experience challenges in verifying the status of former foster youth from out-of-state. To complete the enrollment process, counties must verify the former foster care status of out-of-state youth by contacting the appropriate state. If the county is unable to obtain verification after contacting the state, former foster youth are asked to provide documentation. Former foster youth, however, do not usually maintain records that verify their foster care status. Moreover, former foster youth may not know which county they aged out of foster care. This can make it challenging for the former foster youth to obtain the appropriate documentation, and thus, complete the verification process. DHCS is in the process of creating additional guidelines for county workers to address this issue.

Promising Practices: Outreach and Enrollment

There are a number of promising practices that have been formulated based on lessons learned from the implementation of the Chafee Option and the early ACA enrollment. The following outreach and enrollment strategies have been implemented to a certain extent by counties and community-based organizations throughout California to overcome enrollment barriers for former foster youth into Medi-Cal coverage. The Department of Health Care Services, in partnership with the California Welfare Directors Association, social welfare county agencies, and community-based organizations, is working to strengthen these efforts to ensure former foster youth are able to access Medi-Cal extension coverage in a timely matter.

- **Education and Outreach Targeting Former Foster Youth.** One challenge to enrolling former foster youth in the Medi-Cal program is being able to identify and educate them on the program’s eligibility criteria and benefits. Education and outreach efforts are vital

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*vii* Nine states, including California, have a county-administered child welfare system. Therefore, this problem may only impact a small number of former foster youth from out-of-state.

*viii* The Chafee Foster Care Independence Act of 1999 allowed states to expand Medicaid coverage to former foster youth to their 21st birthday. Commonly referred to as the Chafee Option, 30 states, including California, implemented the option.
to ensure that eligible youth are informed about the program’s benefits and the enrollment process. There are multiple outreach strategies that are effective in spreading the word about the program to this population. Peer-to-peer outreach has been identified as a powerful approach to spreading awareness of the extension. Outreach tools, including social media, educational materials, and forums, have been beneficial in educating former foster youth as well.

- **Designated Specific Point Person or Phone Number at the County Level.** To ensure the successful enrollment of foster youth, counties are recommended to designate a point person or phone number. As the primary contact for former foster youth, this designated person should be knowledgeable about the provision and the enrollment process, and be capable of answering any questions eligible youth may have about the program and its benefits. This allows foster youth to get in contact with someone who is knowledgeable about the extension and the enrollment process. The designated person or call line also ensures that the former foster youth is being provided with the correct information regarding the program. California counties that have a designated point person include, but are not limited to: Alameda, Butte, Calaveras, Fresno, Los Angeles, Santa Clara and Solano.

- **In-Person Staff Member at County Office.** Some counties have assigned a specific person at the county office to help former foster youth. This person would be able to help the former foster youth overcome barriers to enrollment, such as the electronic systems. He or she is also familiar with the work-around needed to get the youth into the system and matched with the correct aid code. Currently, the California Welfare Directors Association is working to identify potential county liaisons to help former foster youth who go to the county office to enroll.

- **Partnerships with Community-Based Organizations and Social Service Providers.** Another important component to the successful enrollment of former foster youth is partnerships with community-based groups and social service providers. Social service providers are in regular contact with youth, and therefore, are in a unique position to identify and educate eligible applicants about the extension. In addition, they can provide youth guidance and support through the enrollment process, and ensure they are able to gain access to the program in a timely manner.

- **Leadership and Collaboration.** The successful implementation of the ACA provision will be highly contingent on the working relationship between the state and local agencies. As California implements the ACA provision, it’s important that DHCS and counties work collaboratively in an effort to identify and enroll former foster youth. This requires maintaining an open line of communication, particularly during the design and implementation of enrollment policies and procedures. In addition to state-county
collaboration, county-to-county collaboration is essential in order to verify the status of former foster youth.

- **Training Administrators and Front Line Staff.** Enrollment workers are instrumental to facilitating the enrollment of former foster youth into the Medi-Cal program at the county-level. Enrollment workers are responsible for processing Medi-Cal applications and determining eligibility. The ACA implementation has triggered significant changes to the enrollment and verification process, to be effective in 2014. Medi-Cal rule changes and other information need to be adequately communicated to county workers and front line staff so they may understand the changes to the enrollment system.

  Currently, DHCS has been providing additional guidance on how to effectively carry out the new verification and enrollment policies. The California Welfare Directors Association also recently sent out a desk aid letter to county workers, which provides concise instruments on the application process for the foster youth population. DHCS is also providing ongoing trainings to help staff and eligibility workers understand these system changes.

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**Promising Practices Highlight: Children Now’s Covered till 26 Campaign**

Children Now, a grantee of the Conrad N. Hilton Foundation, launched a statewide outreach campaign called “Covered till 26” ([http://coveredtil26.childrennow.org/](http://coveredtil26.childrennow.org/)), in an effort to maximize enrollment into Medi-Cal for former foster youth. Through the campaign, Children Now has been disseminating educational resources via fliers, brochures, and blog posts to former foster youth, stakeholders and advocates about the extension and enrollment process. Children Now, in partnership with DHCS and Youth Law Center, also hosted a webinar in February 2014 that provided an overview of the Medi-Cal extension, as well as enrollment tips to overcoming barriers.

Moreover, Children Now is partnering with various agencies, including the Department of Health Care Services, to simplify the enrollment process for former foster youth and educate enrollment workers on the ACA provision. Recently, California County Welfare Association, with input from Children Now, generated an outreach flyer, “Did You Know?” and a desk aid letter for county workers. The desk aid letter provides a comprehensive overview of the extension benefit and instruction on how to enroll eligible youth, while the attached “Did You Know?” flyer provides step-by-step enrollment information for eligible youth. The “Did You Know?” flyer also includes information on Children Now’s CoveredTil26 website.
**Additional Resources**

- **“Implementing the Affordable Care Act: How Much Will It Help Vulnerable Adolescents & Young Adults?”** This publication provides an overview of the implications of the ACA for youth in or aging out of the foster care system, youth involved in the juvenile system, and homeless youth. [http://nahic.ucsf.edu/wp-content/uploads/2014/01/VulnerablePopulations_IB_Final.pdf](http://nahic.ucsf.edu/wp-content/uploads/2014/01/VulnerablePopulations_IB_Final.pdf)

- **Insure the Uninsured Project. “Children’s Health Coverage Under the ACA.”** This issue brief highlights the current and potential future challenges to accessing pediatric patient care following the implementation of the ACA. The issue brief discusses how different populations will be affected by the ACA. Groups include foster care children, children in the juvenile justice system, and children with chronic conditions. [http://itup.org/wp-content/uploads/2014/02/Part-2-Childrens-Health.pdf](http://itup.org/wp-content/uploads/2014/02/Part-2-Childrens-Health.pdf)


- **California County Welfare Directors Association. “Former Foster Care Children’s Program (FFCC) Desk Aid.”** The County Welfare Directors Association generated a desk aid letter for county employees. The letter informs county workers of the changes to the former foster care children’s program, and an overview of the

- **LA County Office of Foster Care Ombudsman.** Former foster youth who are having troubles enrolling into Medi-Cal due to verification challenges can contact the office of the Foster Care Ombudsman. The office has the authority to check the state Child Welfare Service database (CWS) as well, to verify whether or not the youth was in foster care on the day he or she turned 18. This database, however, is only beneficial for former foster youth who were under the care of the state of California. [http://www.fosteryouthhelp.ca.gov/](http://www.fosteryouthhelp.ca.gov/)


- **Children Now. Medi-Cal for Former Foster Youth: County Specific Information.** This document provides contact information on California counties that youth should contact in order to sign-up for Medi-Cal coverage. [http://www.childrennow.org/uploads/documents/Coveredtil26_CountyContactList.pdf](http://www.childrennow.org/uploads/documents/Coveredtil26_CountyContactList.pdf)

- **ASPE. “Providing Medicaid to Youth Formerly in Foster Care under the Chafee Option: Informing Implementation of the Affordable Care Act.”** (Nov. 2012) This report examines states’ implementation of the Chafee Option, and examines lessons learned from the implementation. Best practices were identified to address implementation problems, which include eligibility criteria, data systems, and more. These solutions serve to inform states on how to implement the ACA provision. [http://aspe.hhs.gov/hsp/13/ChafeeMedicaidReport/rpt2.cfm#Toc33650052](http://aspe.hhs.gov/hsp/13/ChafeeMedicaidReport/rpt2.cfm#Toc33650052)
Overcoming Multiple Sclerosis

For more than five decades, the Conrad N. Hilton Foundation has been dedicated to finding a cure and improving the quality of life of persons affected by multiple sclerosis (MS). To achieve this aim, the Foundation’s giving is directed at supporting research that investigates the causes and treatment of multiple sclerosis. In addition to funding research, the Foundation supports the Marilyn Hilton MS Achievement Society at UCLA, which provides comprehensive wellness services for persons with MS, designed to improve functionality and maintain independence.

With the implementation of the Affordable Care Act, the Conrad N. Hilton Foundation was interested in learning about opportunities to enhance the coverage and reimbursement of wellness programs under Medi-Cal. Based on available literature and conversations with the National Multiple Sclerosis Society, the Affordable Care Act does not create any significant changes to the schedule of benefits offered under Medicaid for persons with MS. In addition, the ACA does not create opportunities to enhance wellness programs, with the exception of the enhancement of employer wellness programs.

The ACA, however, does create changes to Medicare that are expected to help persons with MS. Specifically, the Act closes the coverage gap on prescription drugs, commonly referred to as the “donut hole,” and enhances the coverage of preventative services with no out-of-pocket expense. These changes are expected to help reduce the burdensome cost of expensive prescriptions, and improve health outcomes by preventing diseases.

Given the scope of this report, these benefits are not explained in-depth. However, information on these benefits can be found below in Additional Resources.

Additional Resources


End Notes


8 Ibid.


11 Ibid.


15 SAMHSA


39 http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Health-Homes/Health-Homes.html
30 Ibid
39 Ibid.
40 Ibid.
42 Ibid.
46 Ibid
50 Ibid
59 Ibid
60 http://www.hewlett.org/uploads/documents/Healthy_Steps_Toward_Student_Achievement.pdf

63 Ibid.
64 Ibid.
65 Ibid.
66 Ibid.

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68 Ibid.


71 Ibid


74 Ibid


76 Ibid.


79 Ibid

80 Ibid.

81 Ibid.

82 Ibid.

83 Ibid.

