

STATE OF PLAY: COVID-19 AND HOMELESSNESS

As communities across the country are grappling with the spread of COVID-19, people experiencing homelessness (in shelters and the unsheltered) face serious threats where the virus is spreading through the community. Those experiencing homelessness have higher rates of acute primary health care needs, including respiratory disease, and homeless individuals can be at much greater risk of infection and complications from infection. These issues are particularly acute for seniors experiencing homelessness. Homeless shelters present additional challenges for people, given the very close sleeping quarters, most often communal meals, and shared bathing facilities. People living outside on the streets or in encampments are also often living in close quarters and share utensils and other personal items that could transfer disease, including COVID-19. Additionally, people experiencing homelessness usually lack access to basic things like soap and water for hand washing that can help prevent illness and the spread of illness.

Supporting Organizations:

- National Association of Community Health Centers
- National Healthcare for the Homeless Council
- National Alliance to End Homelessness
- UnitedHealthcare Community & State

With COVID-19 spreading quickly, we need a fast and coordinated response from every level of government, as well as collaboration with homeless services providers, Federally Qualified Health Centers (FQHCs) like Healthcare for the Homeless Council, and managed care organizations (MCOs). The National Association of Community Health Centers, National Healthcare for the Homeless Council, National Alliance to End Homelessness, and UnitedHealthcare Community & State have partnered to create a list of recommendations that state and local governments, state Medicaid agencies, and Medicaid health plans can advance to support this particularly vulnerable population during the current critical public health crisis. **Outlined below are concrete actions steps and policy measures that stakeholders should be implementing immediately to limit the spread and impact of the virus and mitigate future exposure.**

CONCRETE AND IMMEDIATE ACTION STEPS

CITY & COUNTY GOVERNMENT & HOMELESS PROVIDERS “ON THE GROUND”

- **Re-organize and re-deploy existing shelter capacity.** Communities should designate a senior shelter for all people experiencing homelessness who are over 55 years old and/or have significant medical conditions. This shelter should stay open 24/7 and provide onsite meals along with daily medical monitoring for cough and fever to allow for the quick identification and triage of someone who feels ill. Those individuals who meet DOH criteria for COVID-19 testing would be referred for testing and prioritized for isolation rooms.

- **Lift any ordinances and require 24/7 shelters.** Mayors and City Councils should lift any existing ordinances or policies that restrict the time shelters can be open, and require shelters to be open 24/7 and dedicate resources to support. This will enable people to rest in place and limit exposure or transmission on public transportation, etc.
- **Create additional capacity to safely house people at risk while supporting the local motel/hotel and service industries.** Local cities and county governments should contract with motels and hotels, which are likely to face mass vacancies in the coming weeks, to safely house seniors and other people at risk who are not yet exposed. Other facilities can be used to isolate people under investigation of exposure. As we saw already in Seattle, motel/hotel facilities, supported by appropriate staff, can be a critical early step towards protecting the populations most at risk with transitional housing capacity.
- **Follow protocols and quarantine individuals testing positive for COVID-19.** Screen visitors and staff to shelter in advance and upon arrival for fever or signs of an acute respiratory illness. Any persons with signs of respiratory illness and who meet potential COVID-19 Persons Under Investigation (PUI) criteria from the CDC should be isolated in a private room with the door closed. If no room is available, a pre-identified location to limit patient's exposure to staff and other patients should be established.
- **Expand Medical Respite Care capacity.** Cities should contract with motels and hotels in their community to secure rooms and additional space for medical respite beds to provide necessary care for who are people chronically ill, COVID negative, and experiencing homelessness and people exiting the hospital who are COVID negative but too sick to be in a shelter. Hospitals, MCOs, and FQHCs need to coordinate services and financing to support the utilization of this program option. (reference paper here)
- **Work with housing providers on plans to transition individuals** from respite to supportive housing, as needed. Recognizing the lack of necessary units, states and localities should prioritize individuals experiencing homelessness with complex health needs.

STATE MEDICAID AGENCIES:

- **Allow use of expanded services for homeless, complex care populations.** Keeping individuals with unstable housing safe will require a broader set of services, including transitional and respite care as described above along with food access, cell phone minutes, and sanitation kits. Managed care organizations have capacity to distribute these essential services immediately, but need collaboration and regulatory clarity in many cases.
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- **Expand Medicaid eligibility for homeless adults.** States should expand coverage to homeless adults to increase access to care and sustain FQHC and hospital services for this population.
 - **Presumptive eligibility for homeless individuals.** State Medicaid program should expand presumptive eligibility to children and adults to expedite the Medicaid application process. Hospitals and safety-net providers, including FQHCs, should be authorized as qualified entities that are able to screen for Medicaid eligibility and temporarily enroll individuals.
 - **Eliminate out of pocket costs.** Co-pays and premiums can be a barrier for individuals experiencing homelessness who may need COVID-19 testing or care. With higher rates of acute care needs, state Medicaid programs should consider waiving cost-sharing for this population.
 - **Suspend prior authorization or utilization management policies.** To further reduce barriers and delivery timely screenings and responses, state Medicaid programs should suspend prior authorization and utilization management policies for COVID-19 testing and related services.
 - **Add Medical Respite as a Medicaid benefit.** Following a hospital discharge, those who are experiencing homelessness need a safe place to rest and recuperate. Medical respite can provide the necessary care and support when an individual doesn't meet the criteria for nursing home care. States should consider adding Medical respite as a covered benefit as providers are working to expand capacity.
 - **Allow FQHCs to bill for services in non-traditional settings.** Individuals experiencing homelessness are less likely to seek out necessary care and testing. It is crucial that providers have the ability to outreach and provide services in the community. Additionally, some individuals may be housed or quarantined in shelters, motels, or other alternative locations to provide them a safe place. To be successful in caring for this population and stopping the spread of COVID-19, states should reimburse FQHCs for eligible services provided in non-traditional settings such as mobile units, encampments, public housing, shelters, and motels.
 - **Promote the use of telehealth.** In addition to permitting Medicaid coverage for telehealth, states should expand eligible technologies at both originating and distant sites and provide payment parity so that services are reimbursed at the same rate as in-person services. This can help FQHCs and other providers to be responsive and meet patient needs while maximizing available resources and limiting staff and patient exposure.
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FEDERAL APPROPRIATIONS

- **Federal stimulus packages should include:**
 - Funding for state and local homeless systems through the Emergency Solutions Grants formula grant programs
 - Funding for emergency housing stabilization and supportive housing through a program similar to the Homeless Prevention and Rapid Rehousing Programs

MANAGED CARE ORGANIZATIONS (MCOs)

- **Deploy housing navigators to provide logistical support.** Managed care organizations with housing specialists or navigators should re-deploy these staff to provide logistical support for shelters, FQHCs, and community stakeholders addressing COVID-19 in their community.
 - **Contract with Healthcare for the Homeless.** If MCOs are not already, they should contract with local Healthcare for the Homeless providers in their community to use Medicaid to finance outreach services, medical services, and other supports (as state rules allow). Healthcare for the Homeless are FQHCs who specialize in serving homeless populations.
 - **Coordinate with FQHCs.** Many FQHCs, particularly Healthcare for the Homeless providers, are already working to respond to COVID-19 and the needs in their community. MCOs should partner with FQHCs to share information about enrollees and providers to ensure care is coordinated, access is sufficient, and emerging needs are addressed in a timely manner.
 - **Finance Medical Respite care.** Managed care organizations should include medical respite as a billable service (as allowed by state) to strengthen and expand medical respite capacity. UnitedHealthcare Community and State has partnered with the National Healthcare for the Homeless Council on a guide to financing medical respite.
 - **Reimburse FQHCs** for eligible services provided to unsheltered Medicaid recipients delivered in encampments, on the street, or other places where the unsheltered recipient resides or is found.
 - **Convene stakeholders to create Medical Respite and other medical transitional housing resources.** Managed care organizations often have contracts with hospitals and FQHCs that are key to developing medical respite programs. These relationships should be leveraged to expand medical respite capacity quickly.
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