U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

MEDICAID FINANCING FOR SERVICES IN SUPPORTIVE HOUSING FOR CHRONICALLY HOMELESS PEOPLE:

CURRENT PRACTICES AND OPPORTUNITIES

February 2012

Office of the Assistant Secretary for Planning and Evaluation

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) is the principal advisor to the Secretary of the Department of Health and Human Services (HHS) on policy development issues, and is responsible for major activities in the areas of legislative and budget development, strategic planning, policy research and evaluation, and economic analysis.

ASPE develops or reviews issues from the viewpoint of the Secretary, providing a perspective that is broader in scope than the specific focus of the various operating agencies. ASPE also works closely with the HHS operating divisions. It assists these agencies in developing policies, and planning policy research, evaluation and data collection within broad HHS and administration initiatives. ASPE often serves a coordinating role for crosscutting policy and administrative activities.

ASPE plans and conducts evaluations and research--both in-house and through support of projects by external researchers--of current and proposed programs and topics of particular interest to the Secretary, the Administration and the Congress.

Office of Disability, Aging and Long-Term Care Policy

The Office of Disability, Aging and Long-Term Care Policy (DALTCP), within ASPE, is responsible for the development, coordination, analysis, research and evaluation of HHS policies and programs which support the independence, health and long-term care of persons with disabilities--children, working aging adults, and older persons. DALTCP is also responsible for policy coordination and research to promote the economic and social well-being of the elderly.

In particular, DALTCP addresses policies concerning: nursing home and community-based services, informal caregiving, the integration of acute and long-term care, Medicare post-acute services and home care, managed care for people with disabilities, long-term rehabilitation services, children's disability, and linkages between employment and health policies. These activities are carried out through policy planning, policy and program analysis, regulatory reviews, formulation of legislative proposals, policy research, evaluation and data planning.

This report was prepared under contract #HHSP23320095624WC between HHS's ASPE/DALTCP and Abt Associates, Inc. For additional information about this subject, you can visit the DALTCP home page at http://aspe.hhs.gov/_/office_specific/daltcp.cfm or contact the ASPE Project Officer, Emily Rosenoff, at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. Her e-mail address is: Emily.Rosenoff@hhs.gov.

MEDICAID FINANCING FOR SERVICES IN SUPPORTIVE HOUSING FOR CHRONICALLY HOMELESS PEOPLE: Current Practices and Opportunities

Carol Wilkins
Martha R. Burt
Danna Mauch

Abt Associates, Inc.

February 24, 2012

Prepared for
Office of Disability, Aging and Long-Term Care Policy
Office of the Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
Contract #HHSP23320095624WC

The opinions and views expressed in this report are those of the authors. They do not necessarily reflect the views of the Department of Health and Human Services, the contractor or any other funding organization.

TABLE OF CONTENTS

PREFACE TO THE ISSUE PAPERS iii
- The Study's First Phase: Literature Synthesis, Environmental Scan, and Site Visits iv
- Second Phase: Case Studies of New Strategies v

HIGHLIGHTS vi

1. INTRODUCTION 1
- 1.1. Medicaid Basics 1
- 1.2. Who is Eligible for Medicaid? 2
- 1.3. What Services Does Medicaid Cover for Permanent Supportive Housing Tenants? 3
- 1.4. Expanded Medicaid Coverage under the Affordable Care Act 4
- 1.5. State Steps Toward Implementing the Affordable Care Act 5
- 1.6. The Rest of This Paper 7

2. FEDERALLY QUALIFIED HEALTH CENTERS 8
- 2.1. Who is Eligible for Federally Qualified Health Center Services Covered by Medicaid? 9
- 2.2. How Do Federally Qualified Health Centers Provide Services to Permanent Supportive Housing Residents? 9
- 2.3. Federally Qualified Health Center Challenges, Obstacles, and Limitations 12
- 2.4. Looking Ahead to 2014: How is the Situation Likely to Change for Federally Qualified Health Centers? 13

3. MENTAL HEALTH SERVICES 15
- 3.1. Who is Eligible for Mental Health Services Covered Under Medicaid? 16
- 3.2. How are Mental Health Services Provided to Permanent Supportive Housing Residents? 17
- 3.3. Challenges, Obstacles, and Limitations of Medicaid-Reimbursed Mental Health Services 21
- 3.4. Looking Ahead to 2014: How is Coverage for Mental Health Services Likely to Change? 24

4. INTEGRATED MODELS THAT COMBINE FEDERALLY QUALIFIED HEALTH CENTERS AND MENTAL HEALTH FINANCING 25
4.1. Integrated Models 25
4.2. Who is Eligible for Integrated Care? 28
4.3. Challenges, Obstacles, and Limitations for Integrated Care 28
4.4. Looking Ahead: How is Coverage for Integrated Care Likely to Change? 29

5. SUBSTANCE ABUSE TREATMENT 30
5.1. Who is Eligible? 30
5.2. How is Substance Abuse Treatment Provided to Permanent Supportive Housing Residents? 30
5.3. Challenges, Obstacles, and Limitations Related to Medicaid Coverage of Substance Abuse Treatment 31
5.4. Looking Ahead to 2014: How are Services for Substance Abuse Likely to Change? 33

6. HOME AND COMMUNITY-BASED SERVICES 35
6.1. Home and Community-Based Services (1915c) Waiver Services 35
6.2. Home and Community-Based Services Option/State Plan (1915i) Services 36
6.3. Who is Eligible for Home and Community-Based Services 36
6.4. How Can Home and Community-Based Services be Provided to Permanent Supportive Housing Residents? 37
6.5. Challenges, Obstacles, and Limitations of Home and Community-Based Services 38
6.6. Looking Ahead to 2014: How is Home and Community-Based Services Likely to Change? 43

7. MANAGED CARE 44
7.1. How Does Managed Care Deliver Services Linked to Permanent Supportive Housing 45
7.2. New Arrangements for Managed Care for Residents of Permanent Supportive Housing 46
7.3. Challenges, Obstacles, and Limitations of Managed Care 47
7.4. Looking Ahead to 2014: How is Managed Care Likely to Change? 47

8. HEALTH HOMES 49
8.1. Who is Eligible for Health Home Services? 49
8.2. Potential for Using the Health Home Option for Residents of Permanent Supportive Housing 50

9. CONCLUSIONS AND IMPLICATIONS 51

PREFACE TO THE ISSUE PAPERS

In 2014, most homeless people will become Medicaid-eligible under the Affordable Care Act (ACA) of 2010 based on their low incomes. Many homeless people have complex physical and behavioral health conditions for which they seek care through frequent use of emergency rooms and inpatient hospitalization, at considerable cost in public resources.

With appropriate supportive services, inappropriate use of crisis health services can be avoided. Medicaid reimbursement is an important source of funding for many of the health, care coordination, and recovery support services that help homeless people succeed in housing and stop such inappropriate use. Among the best indicators of Medicaid's potential usefulness to homeless people once they become beneficiaries are the ways that today's providers have been able to use Medicaid to cover health care and behavioral health care for people who have been chronically homeless and are now living in permanent supportive housing (PSH).

In October 2010, the U.S. Department of Health and Human Services (HHS), Office of the Assistant Secretary for Planning and Evaluation, contracted with Abt Associates Inc. for a study to explore the roles that Medicaid, Community Health Centers, and other HHS programs might play in providing services linked to housing for people who experience chronic homelessness through PSH. **Permanent Supportive Housing** provides a permanent home for formerly homeless people with disabilities, along with the health care and other supportive services needed to help tenants adjust to living in housing and make the changes in their lives that will help them keep their housing. It differs from group homes, board and care facilities, and other treatment programs in that most tenants hold their own leases, and keeping their housing is usually not contingent on their participating in services or remaining at a certain level of illness.

Because Medicaid is implemented through partnerships between states and the Federal Government, every state's Medicaid program is different. Medicaid is only one component of strategies that communities use to create and sustain supportive housing. It does not pay for housing costs, and Medicaid reimbursement is available only for services that address health-related issues. This study focuses on communities known to be using Medicaid to provide integrated health, mental health, and substance use services combined with housing for chronically homeless people. Other states and providers will develop new models of service delivery and reimbursement in the coming years.

The Study's First Phase: Literature Synthesis, Environmental Scan, and Site Visits

The chronically homeless people on whom this study focuses have multiple, complex, and interacting physical and behavioral health conditions. Achieving the best results for these clients and the public institutions and systems from which they get care requires effective engagement, service delivery, and care coordination. To understand how this care is currently being delivered, the research team reviewed both published and unpublished literature and drew on team members' extensive knowledge of successful programs and agencies. The result was "*Medicaid and Permanent Supportive Housing for Chronically Homeless Individuals: Literature Synthesis and Environmental Scan*" (Burt, Wilkins, and Mauch, 2011). This report documents the evidence on the rationale for linking housing assistance with Medicaid-funded health services--specifically, that these services are more clinically effective while also being less expensive than avoidable emergency room use and hospitalizations.

The research team then conducted site visits to see how housing and supportive services worked together in practice. The team identified the relatively few communities in the United States with experienced providers that integrate housing with health, mental health, and substance abuse services. The team conducted site visits to three of these communities--the San Francisco Bay Area, Chicago, and the Boston-Worcester area. The communities visited are not representative; rather, they are examples. Their experiences may be helpful to policy makers and practitioners alike, as they illustrate both what can be accomplished and the many challenges and barriers that must be overcome along the way. A growing number of communities are starting to implement similar approaches.

The research team then produced four issue papers on promising practices linking health, mental health, and substance abuse services to housing assistance for the target population of chronically homeless people:

- **Paper 1**--describes three subgroups of the people experiencing chronic homelessness, and the services and housing configurations currently supporting them. *Health, Housing, and Service Supports for Three Groups of People Experiencing Chronic Homelessness.* Cambridge, MA: Abt Associates Inc., 2012. M.R. Burt & C. Wilkins. [http://aspe.hhs.gov/daltcp/reports/2012/ChrHomls1.shtml]

- **Paper 2**--describes the ways that Medicaid is being used now and might be used in the future under provisions of the ACA to serve chronically homeless people. *Medicaid Financing for Services in Supportive Housing for Chronically Homeless People: Current Practices and Opportunities.* Cambridge, MA: Abt Associates Inc., 2012. C. Wilkins, M.R. Burt, & D. Mauch.

- **Paper 3**--describes innovative approaches to establishing Supplemental Security Income (SSI) eligibility. *Establishing Eligibility for SSI for Chronically Homeless*

People. Cambridge, MA: Abt Associates Inc., 2012. M.R. Burt & C. Wilkins. [http://aspe.hhs.gov/daltcp/reports/2012/ChrHomls3.shtml]

- **Paper 4**--looks at innovative ways that public housing agencies are supporting housing for formerly homeless people in the communities the researchers visited. *Public Housing Agencies and Permanent Supportive Housing for Chronically Homeless People.* C. Wilkins & M.R. Burt. [http://aspe.hhs.gov/daltcp/reports/2012/ChrHomls4.shtml]

Core information about health, housing, and supportive services found in the *Literature Synthesis and Environmental Scan* is not duplicated in the papers. Likewise, Papers 2, 3, and 4 do not repeat the information on subpopulations found in Paper 1. Each paper refers to the others or to the *Literature Synthesis and Environmental Scan* as needed.

Second Phase: Case Studies of New Strategies

The second phase of this study involves case studies of six communities that are on their way toward early implementation of the ACA's Medicaid provisions or other Medicaid-related policies and practices designed to deliver care to chronically homeless people. The study will follow the six communities through fall 2012, watching as they design and implement different strategies that involve Medicaid waivers, state plan options, and other approaches. Future reports will describe these strategies and the progress communities are making.

HIGHLIGHTS

This paper describes the specific ways in which Medicaid reimbursement is being used for some of the services provided to chronically homeless people, including services that address their health and behavioral health needs and help vulnerable people get and keep stable housing. States have used different types of Medicaid benefits and payment mechanism to provide reimbursement for some of the services delivered to people who live in PSH. This report documents some of these approaches and describes both promising practices and challenges or obstacles that have been identified by providers of health care and supportive services and by state and local government officials in several communities. The report also identifies some opportunities for federal policy guidance, and describes some of the ways in which things are likely to change during the next few years with the implementation of the ACA.

In most states, chronically homeless people become eligible for enrollment in Medicaid because they are disabled and receiving benefits through SSI. Many, but not all of these disabled homeless adults have a serious mental illness (SMI). Some homeless adults have other disabling health conditions, including physical disabilities, serious medical conditions, brain injuries or cognitive impairments, and they may also have co-occurring substance use disorders. Homeless people with disabilities may be eligible for and enrolled in SSI and Medicaid benefits, or they may be able to establish eligibility for these benefits with assistance from health care providers and effective benefits advocacy.

In some states homeless people without disabilities, or those whose disabilities are attributable to substance abuse (who are not eligible for SSI), are eligible to enroll in Medicaid under the terms of a state's Medicaid waiver. The ACA also allows states to expand Medicaid eligibility to people on the basis of income, without other "categorical" eligibility criteria, and a growing number of states have done so since the beginning of 2011. In states that have expanded eligibility for Medicaid through waivers or through the provisions of the ACA, homeless people may enroll in Medicaid without demonstrating that they are disabled.

Federally Qualified Health Centers (FQHCs) are providing services in PSH in some communities, often using funding sources that include federal grants from the Health Resources and Service Administration (HRSA) and Medicaid reimbursement. FQHC services may be delivered through home visits or in on-site offices or satellite clinics located in PSH buildings, or through a clinic that is accessible to PSH tenants. Some FQHC providers offer a broad range of health and behavioral health services and other supportive services, using multi-disciplinary team models, while others offer clinical services in partnership with other organizations that provide behavioral health and other services.

The FQHC Medicaid reimbursement mechanism provides payment to providers based on face to face encounters between Medicaid-eligible individuals and certain types of licensed clinicians, including doctors, mid-level primary care practitioners, psychiatrists, and licensed clinical social workers, but does not directly reimburse costs associated with services provided by other providers of health care or behavioral health services, such as nurses and some mental health workers, or services of case managers and medical social workers. Costs for some members of interdisciplinary teams who work in PSH have been disallowed in the determination of FQHC payment rates in some states, despite evidence of the effectiveness of these team models of care for homeless people with complex health and behavioral health problems who have not been effectively engaged or served by other types of health care and treatment programs.

Many of the FQHCs that provide services to chronically homeless people, including services in PSH, receive funding through HRSA's Health Care for the Homeless (HCH) program. There is a need to clarify federal policy and provide guidance to HCH programs about how long they can continue to serve people who have been homeless after they move into PSH.

Medicaid-reimbursed mental health services, including services covered under Medicaid's Rehabilitation Option are frequently delivered as part of PSH programs that serve homeless people with SMI. There is significant variation among states in definitions of covered services, provider qualifications, medical necessity criteria, utilization management systems and procedures, and payment mechanisms. In some states fiscal responsibility for the non-federal portion of Medicaid reimbursement for mental health services is shared with or shifted to counties, and some or all Medicaid mental health or behavioral health services may be administered separately from other health benefits through "carve-out" and/or managed care arrangements.

Depending on the provisions of State Medicaid Plans, reimbursement may be available for services such as Assertive Community Treatment (ACT), Community Support Teams (CSTs), or other flexible, mobile, community-based services that support managing symptoms of mental illness and restoring functioning impaired by mental illness. Services can focus on skill-building to develop interpersonal and community-living skills. Some of these service models allow--and may require--the delivery of services outside of clinic or office settings, in a person's home or other community setting. Some states allow Medicaid reimbursement for peer counselors or other staff members who do not have clinical licenses, but have some combination of education, training, and/or personal experience.

Medicaid reimbursement can cover a substantial portion of the costs of the services PSH offers to help homeless people with SMIs get and keep community housing and achieve health and recovery goals. Documentation requirements for Medicaid reimbursement of these services can be challenging for some supportive housing providers, and mental health benefits may not include coverage for some services that PSH tenants need--including services to address chronic health conditions

or support to access medical care, and some services that address co-occurring substance use problems or other issues that could result in a return to homelessness. PSH service-providers deliver many supportive services that are not Medicaid reimbursable mental health or behavioral health services.

Often medical necessity criteria used to determine whether a person is eligible to receive mental health services focus only on diagnoses, symptoms, and functional impairments related to a diagnosis of mental illness, and do not consider other co-occurring health disorders or risk factors related to homelessness. In some states, such as Illinois, criteria include consideration of other factors such as repeated arrests or incarcerations, chronic homelessness, public intoxication, or high use of detoxification services. For homeless people with mental illness, consideration of these co-occurring disorders and risk factors recognizes the complexity of health challenges among people who need and can benefit from the types of services most often reimbursed by Medicaid in supportive housing.

These benefits are generally available only to persons with SMIs. Some chronically homeless people with other disabling health conditions, including for example those with serious chronic medical conditions, milder forms of mental illness such as depression, cognitive impairments and/or long-term substance use disorders, could benefit from similar types of services that incorporate self-management of chronic health conditions, engagement in effective treatment and recovery support, reduction in high-risk behaviors, and support for community-living skills. However these models of service are generally not covered as Medicaid benefits for people who do not have a diagnosis of SMI, even if they are enrolled in Medicaid.

In many states the systems of financing and delivering health, mental health and substance use treatment and recovery services are highly fragmented. As a result, there may be limited incentives for the system responsible for mental health services to invest in services that reduce costs in the health care system, particularly if costs and savings appear in different budgets or even in different state or local government entities. This can make it challenging for program administrators or policy makers to link savings from reduced hospitalizations to investments in community mental health services.

A few organizations are developing and implementing integrated **models of health and behavioral health care that combine Medicaid-reimbursed FQHC and mental health services.** These integrated models may be developed when a single organization, such as a HCH program, develops the capacity to deliver services through multiple programs, contracts and financing mechanisms that operate within the same organization. State rules may require that these programs operate with separate staff, licenses, record systems, and payment mechanisms, creating challenges when agencies seek to integrate services to meet the complex health, behavioral health, and support services needs of chronically homeless people.

In other cases, primary care and behavioral health services may be integrated when two provider agencies enter into partnerships, with each agency meeting the requirements and using the Medicaid payment mechanisms associated with separate systems of health care and mental health or behavioral health services. Even when services are provided by staff members who work for different organizations, some partnerships work to integrate the delivery of primary care and behavioral health services through interdisciplinary teams that regularly share clinical information and collaborate to engage and deliver care to chronically homeless people with very complex health problems and support them in PSH.

Medicaid reimbursement for substance abuse services is limited in many states, and frequently there is no Medicaid reimbursement for services that are delivered outside of designated substance abuse treatment facilities. As a result, reimbursement is generally not available for the services delivered in PSH that focus on substance abuse problems, including motivational interviewing, counseling to support recovery goals and prevent relapse, crisis intervention and services that help to encourage people to use more formal treatment services or to manage health risks associated with co-occurring chronic illness and substance use disorders.

Medicaid reimbursement is available for **Home and Community-Based Services (HCBS)** for some persons with disabilities, in states that provide benefits covered under waivers or optional benefits. HCBS benefits may include flexible services and assistance to help people with disabilities live independently, instead of in nursing homes or other restrictive settings. However in most states, the housing and service models and Medicaid payment mechanisms that have been developed for people with disabilities who are coming from (or being diverted from) nursing homes or institutional settings are not aligned or coordinated with the supportive housing models and Medicaid payment mechanisms used for chronically homeless people with disabilities, and there are different service-providers and government officials involved with linking housing and services for these populations, in spite of the similarities and overlaps between these two groups of disabled people. One challenging issue is differing perspectives on the meaning of “living in an integrated setting” and debates among some advocates and policy makers about the appropriateness of site-based supportive housing in which all or most of the units are designated for homeless people with disabilities.

Managed care financing and care delivery systems may offer opportunities and incentives to use Medicaid to pay for services that improve health outcomes and reduce avoidable hospitalizations or emergency room visits, and may provide some flexibility for health plans or provider networks to use capitated payments to cover some services that might not be reimbursed in a fee for service payment system, if they can be justified by offsetting savings in other health care costs. So far there has been limited experience with managed care plans paying for services in PSH, but there have been promising initiatives in a few states including Massachusetts and Pennsylvania. With growing numbers of people with disabilities enrolling in Medicaid managed care, there may be new opportunities or additional experience in the next few years.

Emerging models and new Medicaid options, including Accountable Care Organizations and health homes may provide new opportunities for Medicaid reimbursement for services in PSH. In the current economic and fiscal climate, states are likely to be hesitant to offer new types of benefits if they cannot be confident of their ability to control state costs or achieve offsetting savings, but there may be potential opportunities for innovative programs that can achieve and facilitate reinvestment of significant savings from reductions in avoidable hospital care and other high-cost health care service utilization while improving health outcomes.

1. INTRODUCTION

This paper describes the variety of ways that Medicaid, in combination with other funding sources, may cover the costs of health and other services for chronically homeless people, both before and after they move from homelessness to housing. Most of this paper focuses on specific service and funding mechanisms that include Medicaid, describing the service or funding structure, who is eligible, the challenges involved in using Medicaid, opportunities for federal guidance to address the challenges, and what may change with each approach as states move toward full implementation of the Affordable Care Act (ACA) in 2014. First, however, it is important that readers understand a few of the basic ways that Medicaid works.[1]

1.1. Medicaid Basics

Medicaid is implemented through partnerships between states and the Federal Government, with each paying part of the cost. Each state must develop a State Medicaid Plan that describes the benefits its program will provide, and must have this plan approved by the U.S. Department of Health and Human Services' (HHS's) Centers for Medicare and Medicaid Services (CMS). Federal law and CMS regulations prescribe a core set of benefits that each state must provide.[2] States may decide to cover additional optional services,[3] and may limit eligibility for certain additional services to specific groups of people. States may modify their Plan's coverage of services beyond the federally-mandated core, including changes in provider qualifications, definitions of covered services, target populations, and payment mechanisms for optional benefits. States must obtain CMS approval for all such modifications through State Plan Amendments (SPAs).

Federal law also allows states to seek waivers of certain Medicaid rules and regulations. Two kinds of waivers are authorized under federal law--Section 1115 and Section 1915. States may apply for a Section 1115 waiver to obtain program flexibility to test new approaches to financing and delivering Medicaid. States may apply for Section 1915 waivers to introduce managed care arrangements (under 1915(b)) or to provide

---

[1] The Kaiser Commission on Medicaid and the Uninsured has published *Medicaid: a Primer* which explains key information about the Medicaid program. This publication, available at http://www.kff.org/medicaid/upload/7334-04.pdf provides clear explanations about Medicaid for readers who want more information about mandatory and optional benefits, waivers, and other terms that are used in this report.

[2] Mandatory benefits include inpatient and outpatient hospital services; nursing facility, rural health clinic, FQHC, prenatal and freestanding birth center services; physician, nurse-midwife, and certified pediatric and family nurse practitioner services; home health, family planning, tobacco cessation, laboratory, X-ray services; and early and periodic screening, diagnostic, and treatment services for children under age 21.

[3] Optional benefits include clinic services; prescription drugs; rehabilitative services; case management, HCBS services as an alternative to institutionalization, physical, occupational, speech, hearing, and language therapy; diagnostic, screening, and a variety of other services that may be approved by CMS.

long-term care in home and community-based rather than institutional settings (under 1915(c)). Waivers have sometimes been used to expand Medicaid eligibility to people who otherwise were not eligible (prior to passage of the ACA), to implement changes in Medicaid payment and delivery systems through managed care, and/or to provide Medicaid coverage for some of the services that are needed by chronically homeless people and PSH tenants. Some examples of waivers that allow states to provide services to chronically homeless people and PSH tenants will be described in this paper.

1.2. Who is Eligible for Medicaid?

Until the ACA is fully implemented in 2014, Medicaid eligibility is based on income and also is "categorical." Only some income-eligible people are in eligible categories defined by age, disability, or eligibility for another program. Among chronically homeless people, Medicaid eligibility is usually dependent on having a disability that makes the person eligible for Supplemental Security Income (SSI).[4]

Chronically homeless people may qualify for SSI on the basis of SMI. Many chronically homeless people are seriously mentally ill, and may already be enrolled in SSI and therefore Medicaid. Others could participate in Medicaid through qualifying for SSI. Estimates of the prevalence of SMI among chronically homeless people vary, in part because of differences in data collection methods. A recent study of more than 3,000 chronically homeless adults in Philadelphia found that 75 percent of respondents had SMI.[5] Surveys of more than 18,000 people in about 40 communities, most of whom were living on the streets, used a Vulnerability Index and found that 45 percent of respondents had SMI.[6]

Chronically homeless people without SMI may be able to establish eligibility for SSI and Medicaid on the basis of other disabling health conditions such as HIV/AIDS, cancer, heart disease, amputations, or mobility impairments. These disabling health conditions may be complicated by mental disorders that would not by themselves create eligibility for SSI, including depression, anxiety, and post-traumatic stress disorder. They also may have substance abuse disorders.

Substance abuse is a particularly complicated issue for SSI because, starting January 1, 1997, federal law and SSI regulations disallowed eligibility for SSI if substance abuse was the primary diagnosis or substance use "contributes materially" to

[4] Strategies currently being used to improve access to SSI and enrollment in Medicaid are covered in Issue Paper #3. A few chronically homeless people may qualify for Medicaid through participation in Temporary Assistance for Needy Families (i.e., pregnant women and people with minor children staying with them).

[5] Stephen R. Poulin, Marcella Maguire, Stephen Metraux, and Dennis P. Culhane. "Service Use and Costs for Persons Experiencing Chronic Homelessness in Philadelphia: A Population-Based Study." *Psychiatric Services* 61.11(2010): 1093-1098. Available at: http://works.bepress.com/dennis_culhane/99.

[6] One Year Anniversary Report: 100,000 Homes (2011). Available at http://100khomes.org/sites/default/files/images/100khomes_1yr_report_FINAL.pdf.

disability. If a disabling impairment would still exist if the person stopped using drugs or alcohol, it is acceptable as a basis for SSI eligibility. People with some serious and disabling medical conditions that result from substance use (such as chronic liver disease) may be eligible for SSI. If, however, drug abuse or alcoholism is deemed “material” to the disability because evidence establishes that the person would not be disabled if drug or alcohol use stopped, the condition is not a basis for SSI eligibility and an application would be denied.[7]

1.3. What Services Does Medicaid Cover for Permanent Supportive Housing

Medicaid eligibility provides access to many health services and a mechanism for paying for them. For beneficiaries, Medicaid covers the hospital services that make up a big part of total health care costs, as well as doctor visits and other ambulatory health services that may be delivered in hospitals or in clinical settings. Some Medicaid-covered services can be delivered in other community settings, including in a person’s home.

Many of the mental health and substance use treatment services needed by people in PSH are not mandatory benefits in the Medicaid program. Instead, states may provide coverage for these services as optional benefits. States may also set additional criteria that determine who is eligible to receive specific services. These “medical necessity” or “service access” criteria may take into consideration diagnosis, health and health-related needs, functional limitations, and/or other factors.

All Medicaid services must be “medically necessary,” clinically efficacious, and cost-effective. CMS has generally given only limited guidance about the criteria or processes that states establish for determining medical necessity or need for services, so states have significant flexibility to set their own.[8] States establish these criteria to balance several purposes, including controlling service use and costs, ensuring that the limited services available go to those who need them the most, and avoiding the use of limited resources to pay for services that are not needed or are unlikely to be effective. The degree of state flexibility in setting these criteria depends on whether the service is federally-mandated or a state option, and also on whether the service is offered through a program authorized under a Medicaid waiver approved by CMS.

An important point for the chronically homeless population and those living in PSH is that, while they may be eligible for Medicaid, if they are not seriously mentally ill they generally are not eligible for most community-based mental health services, which are

---

[7] Patricia Post, Yvonne Perret, Sarah Anderson, Mark Dalton, and Barry Sevin. 2007. *Documenting Disability for Persons with Substance Use Disorders & Co-occurring Impairments: A Guide for Clinicians*. Nashville, TN: National Health Care for the Homeless Council, Inc.

[8] For a good explanation of the framework for state flexibility in defining service eligibility, see Chapter 3 in *Understanding Medicaid Home and Community Services: A Primer*. http://aspe.hhs.gov/daltcp/reports/2010/primer10.pdf.

often limited to serving persons with serious mental illness (SMI) or severe and persistent mental illness (SPMI).[9] Persons without SMI or SPMI may qualify for a few hours of assessment or stabilization services in the event of a temporary acute mental health crisis. If medically necessary, they may also qualify for emergency and inpatient care, which is most often provided in a local hospital. Medicaid-covered benefits might also include limited counseling services or medications prescribed by a physician (for example, to treat depression). Similarly, coverage for substance abuse treatment and recovery support services usually is very limited.

1.4. Expanded Medicaid Coverage Under the Affordable Care Act

In 2014, nearly all Americans with incomes below 133 percent of the Federal Poverty Level (FPL) will become eligible for Medicaid, without the requirement that they meet additional categorical eligibility criteria. Some people will be ineligible because of immigration status.

Newly eligible people who did not previously qualify for Medicaid on the basis of age, disability, or other categorical criteria are likely to get coverage for a "benchmark" benefit package that may not include some of the services covered under "full scope" Medicaid.[10] According to the ACA, the "minimum essential benefits" offered by the benchmark benefit plans must include treatment services for mental health and substance use disorders as well as rehabilitation and "habilitative" services.[11] Behavioral health treatment cannot be more limited than treatment for physical conditions.

---

[9] The term "community-based mental health services" refers to an array of treatment and support services that allow people with mental illnesses to live in community settings instead of in institutions. These services may be provided in local clinics, residential or outpatient treatment programs, and other settings, including PSH. Community-based mental health services are increasingly delivered by mobile service-providers who may visit people where they live, work, or engage in daily activities.

[10] "Benchmark" benefit plans are based on coverage available in the private sector from large managed care plans or the package of health insurance coverage provided to state employees. For more information about the issues related to Medicaid benchmark benefits and coverage of the range of services needed by chronically homeless people, including services to address mental health and substance abuse problems, see this analysis by the National Council for Community Behavioral Healthcare http://homeless.samhsa.gov/ResourceFiles/Medicaid%20Benchmark%20Coverage%20Health%20Reform.pdf.

[11] Rehabilitation helps people recover lost skills, while "habilitative" services help people acquire new ones. The difference is subtle but it can be important. For example, rehabilitation can help people with schizophrenia improve social skills that allow them to resume participation in activities that had once been a part of their lives before the onset of their mental illness. Assessment for rehabilitation services includes a focus on identifying the level of functioning people had "at baseline" before they became disabled. Service-providers say that some chronically homeless people need to restore skills that they had prior to becoming disabled, while others may need to learn new skills for independent living, particularly if they experienced mental illness, addiction, homelessness, or institutionalization as young adults and never experienced stable independent living in community housing. Precise definitions under ACA are under development. http://www.pizaazz.com/2011/04/01/are-habilitative-services-part-of-essential-care/.

HHS will provide additional guidance and rules for benchmark services, which may have a significant impact on the scope of services that will be available to newly eligible Medicaid beneficiaries, including chronically homeless people and formerly homeless people who are residents of PSH. However, state policy decisions will determine whether Medicaid will cover many of the services that are most often delivered in PSH, since many of these services will still be considered "optional benefits." States will continue to decide whether to provide these services as covered benefits, as well as the qualifications that providers must meet before they can be certified to receive Medicaid reimbursement for the services they deliver.

1.5. State Steps Toward Implementing the Affordable Care Act

Some states are already moving to implement provisions of the ACA that allow them to expand coverage right now to include people living in poverty or near-poverty who do not have categorical eligibility for Medicaid. Other states are using Medicaid's 1115 waivers as a "bridge to reform." As research and demonstration projects, these waivers allow states to extend some form of coverage to people who do not qualify on the basis of current categorical eligibility criteria.

- Under a Medicaid waiver, the Massachusetts Medicaid program provides benefits through MassHealth to designated groups of low and moderate-income people who would not otherwise meet categorical eligibility requirements. MassHealth offers health care benefits directly or by paying part or all of the health insurance premiums for qualified persons. Eligibility varies by coverage type, and qualifications and benefit packages are specified for each group of eligible persons. Chronically homeless people in Massachusetts are nearly all eligible for Medicaid, under the following types of coverage:

  - MassHealth Standard, which serves disabled SSI recipients.
  - MassHealth Basic, for those unemployed for a year or longer without other benefits.
  - MassHealth Essential, for those who are long-term unemployed but whose immigrant status bars them from MassHealth Basic.
  - CommonHealth--in the less likely scenario that they are over 65, disabled, and working 40 hours per month (e.g., some long-term shelter residents).

  The level of coverage and types of services available for behavioral health care differ among these coverage packages. For example, MassHealth Standard and CommonHealth have more robust behavioral health benefits.

- In California, a recently approved Medicaid waiver establishes expanded coverage under a new Low-Income Health Program (LIHP) that counties will design and implement, with counties providing the funds to match Federal Financial Participation (FFP). This strategy will likely produce significant

variations among California counties as they determine who will be eligible and what services the LIHP will cover.

- Maine has used a Medicaid waiver to establish coverage for limited health benefits for “non-categoricals” and has been able to enroll many chronically homeless people who have not gone through the SSI disability determination process. Because there is a cap on the number of people who can be enrolled under this provision of the waiver, the Maine Medicaid office also assesses “non-categoricals” to see if their disabilities are sufficient to qualify them for full scope Medicaid. The office has been able to qualify about two-thirds of “non-categoricals,” as disabled, which moves them from the “non-categorical” group into being “categorically eligible” and frees up “non-categorical” slots for new people. Individuals who have been re-classified in this way are strongly encouraged to apply for SSI, as the criteria to establish disability used by the Medicaid office are the same as those used by SSI, and qualifying for SSI would give people an income source in addition to their Medicaid coverage.

- Connecticut was the first state to get federal approval to expand Medicaid income eligibility under ACA provisions. New Medicaid coverage replaces the state-administered General Assistance medical program and provides full Medicaid benefits for low-income adults who do not receive SSI or Medicare and are not otherwise eligible for Medicaid. Income eligibility for adults age 19-64 is 56 percent of FPL, except in southwestern Connecticut, where it is effectively 68 percent of FPL.

- In May 2010, the District of Columbia (DC) filed a Medicaid SPA, expanding Medicaid eligibility under the authority provided by ACA to cover legal residents with incomes up to 133 percent of FPL who were not previously categorically eligible, and enrolled about 33,000 new beneficiaries. A few months later DC received approval of a waiver to increase the eligibility level to 200 percent of FPL, which added a few thousand more people to the Medicaid rolls. Nearly all of the homeless people who had previously been unable to meet Medicaid’s categorical eligibility requirements are now covered by Medicaid benefits. They are primarily single persons with substance use conditions.

- Minnesota has also opted for early adoption of the ACA Medicaid expansion provisions. Newly eligible people will include an estimated 32,000 General Assistance Medical Care (GAMC) clients, 51,000 low-income adults from the MinnesotaCare program, and 12,000 uninsured persons. Before this expansion, homeless people served in the GAMC program could get care only in four safety net hospitals in the Twin Cities, which were too far away for many people to use. Now homeless people will have care delivered by Medicaid providers throughout the state.

1.6. The Rest of This Paper

Based on the results of site visits and telephone interviews conducted in early 2011,[12] this paper describes several different service approaches and financing mechanisms that have already been implemented or are in development to provide Medicaid reimbursement for services for chronically homeless people and residents of PSH.

The remaining sections of the paper are organized according to the Medicaid financing mechanisms and service approaches that are most frequently used in connection with PSH:

- Federally Qualified Health Centers (FQHCs), including Health Care for the Homeless (HCH) programs and Community Health Centers (CHCs).
- Mental or behavioral health services, including services covered under the Rehabilitation Option and benefits that may be covered through "carve-outs."
- Models that integrate FQHC and mental/behavioral health financing mechanisms.
- Substance abuse treatment.
- Home and community-based services (HCBS) to support people in the community who would otherwise enter nursing homes or other expensive residential care.
- Managed care.
- The health homes option.

These financing mechanisms and service approaches are not mutually exclusive. As will be evident, the providers and programs highlighted in this paper often used more than one.

[12] We conducted site visits in the Boston/Worcester area, the San Francisco Bay Area, and Chicago. These communities were selected because each offers at least one Medicaid provider that integrates care for the physical health, mental health, and substance abuse conditions of chronically homeless people and does so as people move from the streets to housing. Each of the three communities also offers numerous other PSH programs from which we could learn whether and how Medicaid was being used to cover some of the costs of supportive services. We augmented these visits with calls to other communities.

2. FEDERALLY QUALIFIED HEALTH CENTERS

FQHCs are community-based providers of comprehensive primary care, serving medically underserved communities and vulnerable populations. FQHCs operate in many high-need, underserved communities across the country but do not always focus services on people who are homeless. FQHC services are less likely to be available in rural than in urban communities.

FQHCs are CHCs (Health Centers) and HCH programs that receive grants from HHS's Health Resources and Services Administration (HRSA). They receive Medicaid reimbursement for covered services provided to eligible people. In addition to Health Centers and HCHs, a small number of similar providers qualify for Medicaid's FQHC reimbursement under "look-alike" provisions. In this paper we refer to all of these organizations as FQHCs or Health Centers. Some Health Centers also receive grants from HRSA to operate Public Housing Primary Care (PHPC) programs that serve residents of public housing and other U.S. Department of Housing and Urban Development (HUD)-assisted housing.

The rates at which FQHCs receive Medicaid reimbursement are calculated under a payment mechanism specific to FQHCs and usually are significantly higher than Medicaid rates paid to other health care providers for ostensibly similar services.[13] FQHC rates are based on a calculation that divides the Health Center's total reasonable costs for delivering health services by the total number of patient encounters. Medicaid reimbursement is provided to FQHCs only for face to face encounters between specified types of providers and patients who are enrolled in Medicaid.

FQHCs are able to provide services to PSH residents regardless of whether the person is enrolled in Medicaid or has a particular diagnosis or type of disability because, in addition to Medicaid reimbursement, most FQHCs also receive federal grant funding administered by HRSA. This grant funding, often combined with other funding sources, allows Health Centers to provide care to people who do not have insurance coverage through Medicaid or any other source. Health Centers generally use a sliding fee scale, with patient fees adjusted based on income. For homeless people with or without Medicaid, there usually is little or no charge to the patient for care provided by the FQHCs.

---

[13] A full discussion of FQHC payment mechanisms is beyond the scope of this Issue Paper. For more information see https://www.cms.gov/smdl/downloads/SHO10004.pdf.

2.1. Who is Eligible for Federally Qualified Health Center Services Covered by Medicaid?

FQHC clients include people who are low-income, uninsured, and have limited access to health care services. Many FQHC clients are not currently eligible for Medicaid or, if they are eligible, they need help enrolling in the program. FQHCs receive Medicaid reimbursement for services they deliver to Medicaid beneficiaries, and may use grants or other sources of funding to cover costs of care provided to people who are uninsured.

Chronically homeless people and those who have become PSH residents are eligible to become FQHC clients if there is an FQHC in their vicinity. Some FQHCs (HCH programs) serve *only* homeless people and those who have recently moved into housing. Others are CHCs; these agencies do not receive grant funding to operate HCH programs, but they have made a commitment to serving homeless and formerly homeless persons, or they serve these populations as part of a broader mission of serving people living in a low-income community. As noted below, some FQHCs are assessing how much they want to, and can afford to, become involved in serving a significant number of PSH tenants.

2.2. How Do Federally Qualified Health Centers Provide Services to Permanent Supportive Housing

In each of the three communities visited for this project, FQHCs are actively involved in delivering services to PSH residents. These Health Centers use several different models of service delivery. Most are well-established organizations that have been serving homeless people or other vulnerable populations with complex health problems for a decade or longer. In some cases, the public or non-profit organization that operates as an FQHC also develops and operates PSH, using a separate housing subsidiary that is part of the larger organization. In other cases, the FQHC delivers health care and supportive services in partnership with other organizations that develop and operate the housing or that administer rental assistance for use in the private market.

The FQHCs provide services linked to PSH through one or more of the following models:

- Delivering on-site services in PSH through home visits or satellite clinics located in PSH buildings.

- Operating a clinic that is easily accessible by PSH residents and designed to meet their needs.

- Partnering with a mental/behavioral health service-provider that provides outreach to vulnerable homeless people and delivers care to residents of

scattered-site PSH through a multi-disciplinary team of primary and behavioral health care providers.

- Engaging “frequent users” of emergency room care and formerly homeless patients being discharged from hospitals and linking them to permanent housing.

Heartland Health Outreach (HHO)

HHO is a HCH FQHC that operates its own clinics and outreach and also subcontracts with several other organizations. HHO does primary care outreach to 150 residential and drop-in locations throughout the City of Chicago, as well as some in Cook County and surrounding counties. PSH tenants can often get scheduled care in their own building. If they need care between scheduled visits, they can go to the main clinic, which is within walking distance of many supportive housing buildings, or to a clinic at another housing site. PSH tenants may see the same clinician at the main clinic and in their housing and are encouraged to come into the main clinic for care as a way to extend engagement. The enhanced Medicaid payment rates provided under FQHC financing allow HHO to use other sources of funding (e.g., HRSA grants) to serve some PSH residents who have no insurance. These payment rates are significantly higher than the rates paid to non-FQHC primary care providers or psychiatrists.

Often an FQHC will deliver services through on-site staff in some PSH buildings, while also operating a clinic that serves PSH tenants from the surrounding neighborhood and partnering with other organizations to do outreach and provide services linked to scattered-site supportive housing.

FQHCs may use multiple financing mechanisms, receiving Medicaid payments for services that can be reimbursed through the FQHC mechanism and obtaining certification to provide mental health or substance abuse treatment services in programs that are reimbursed separately through state or county contracts or separate Medicaid payments for specialty mental health services. Medicaid-covered specialty mental health services, which may include services provided by programs that are not included in the costs covered by FQHC payment structure, are described in the next section of this paper.

In both San Francisco and Alameda County, California, FQHCs operate clinics that are located adjacent to or within a few blocks of PSH sites.

The San Francisco Department of Public Health (SFDPH) Housing and Urban Health (HUH) clinic delivers services to more than 1,000 PSH tenants who live in supportive housing sites citywide. More than 90 percent of medical and psychiatry services are provided at the HUH clinic, where HUH clinicians and program managers believe the care is better and the clinician more productive than if delivered in-home. The clinician may visit the housing site and persuade tenants to come see the clinician at the clinic after establishing a relationship.

Most of the staff employed by HUH are doctors (including psychiatrists) and mid-level practitioners or nurses; HUH employs relatively few case managers who are not licensed. HUH nurses work at several PSH sites, where they assess and monitor health

needs of tenants and help with medication management. PSH sites that are part of the HUH Direct Access to Housing program usually also have on-site case managers employed by a partner organization, which may be a community mental health agency or a homeless service-provider. These on-site case managers are usually not supported by Medicaid reimbursement. They are funded separately, through HUD McKinney-Vento grants (Supportive Housing Program (SHP) services-only) or from county resources.

Boston Health Care for the Homeless Program (BHCHP)

BHCHP provides services by using integrated mobile teams. Most clients have multiple chronic health conditions, including medical and behavioral disorders. Treatment and supportive services are delivered by teams that include physicians, physician assistants, nurse practitioners, nurses, case managers, and behavioral health practitioners. Team members work collaboratively to deliver care to homeless people on the streets, at McInnis House medical respite, in outpatient primary care, in behavioral health and dental clinics in several locations, in shelters, or in housing. Continuity of caregiving relationships is maintained across settings for the same people. BHCHP integrates primary care, behavioral health care, dental care, vision, pharmacy, and case management services, as well as linkage to a range of non-medical supports.

To cover the range of services it offers, BHCHP:

- Obtains FQHC Medicaid reimbursement, which covers medical and nursing care provided in-clinic and medical respite services.
- Receives reimbursement through MassHealth's Massachusetts Behavioral Health Partnership (MBHP) for a pilot program serving a targeted group of chronically homeless people with co-occurring SMI and substance use conditions.
- Covers street and home-based clinical team services with its HCH grant from HRSA, and reimbursement from MassHealth for services to eligible clients.
- Does fundraising and seeks foundation grants for capital and operating funds for selected services, particularly specialty dental and medical respite services.
- Seeks alternative funding to cover the work of non-medical personnel (e.g., social workers, psychologists, case managers) that cannot be billed under the FQHC financing mechanism.

In Alameda County, Lifelong Medical Care received a HRSA grant to provide services as a PHPC Clinic, which allowed it to establish a clinic in a downtown Oakland neighborhood within a few blocks of several HUD-assisted PSH buildings. At the clinic, Lifelong provides comprehensive primary care and some behavioral health services for PSH tenants and residents of nearby public housing developments and other HUD-assisted housing. Some Lifelong clinic staff members also deliver services on-site in PSH buildings. In some buildings, a room is set up as a satellite clinic with an exam table so that primary care providers (usually nurse practitioners or nurses) can visit residents where they live.

Lifelong employs staff who work full-time (or several days a week) in site-based PSH buildings. They include a licensed clinical social worker (LCSW) who provides counseling for mental health and substance abuse problems and social workers or case managers who help tenants with a range of issues related to housing stabilization,

access to benefits and social supports, and engagement and linkage to health and treatment services. Some PSH sites have additional on-site services provided by collaborating partner agencies.

Partnerships between FQFCs and supportive housing providers are under development in other regions. In Hartford, Connecticut, for example, a new Health Center clinic is being constructed adjacent to a PSH project. In Los Angeles, the Corporation for Supportive Housing and United Homeless Healthcare Partners recently released "Integrating FQHC Health Care Services with permanent supportive housing in Los Angeles," a publication that describes program and financing strategies currently in use or under consideration.[14]

2.3. Federally Qualified Health Center Challenges, Obstacles, and Limitations

While some FQHCs have succeeded in providing comprehensive care to PSH residents, they have had to overcome challenges created by the current Medicaid system that include incomplete coverage of services, billing rules that make integrated care difficult, and ambiguity about how long HCH providers can serve people in supportive housing who no longer are homeless.

2.3.1. The Work of Essential Team Members Is Not Covered by Medicaid Reimbursement

Health Center staff interviewed for this study explained that the total costs of providing service that are used for the purpose of setting FQHC payment rates do not include the costs for some of their unlicensed social workers, case managers, peer counselors, and mental health or substance abuse specialists. These staff members work as part of interdisciplinary teams serving homeless people in clinics and on-site in PSH and are often a good part of the "glue" that helps to engage vulnerable people in integrated and coordinated care. Their exclusion from rate-setting affects the rates for the reimbursement FQHCs receive for both the direct providers of clinical care and ancillary or support staff. Care not billed directly may be reimbursed indirectly if included in the calculation of the Health Center's FQHC payment rate for visits with licensed providers. If some of these costs are disallowed, the FQHC receives a lower payment rate for *all* "billable" encounters.

Some of the programs we interviewed attempted to solve this problem by co-locating staff paid by the FQHC and by another agency. They sometimes have licenses for two clinics--medical and behavioral--in adjacent spaces, to integrate their services for the client while complying with disparate licensing and reimbursement requirements. Grant funding and flexible funding from states or local governments sometimes can pay for costs that Medicaid does not cover.

[14] See http://documents.csh.org/documents/ca/IntegratingHealthReport_FINAL.pdf.

2.3.2. Multiple Care Encounters on the Same Day May Not Be Billable

In many states, FQHC providers cannot receive reimbursement for more than one visit by the same patient in the same day. That makes is difficult for FQHCs to integrate medical and mental health services. Providing medical and mental health services in the same location on the same day can be an effective way to engage people with long histories of homelessness, who have often been disaffiliated from care and reluctant to seek treatment. Asking the client to come back another day to see a different practitioner may not work. Recognizing this problem, Massachusetts has eliminated the same-day billing exclusion.

2.3.3. Medicaid Reimbursement Often Does Not Cover All of the Costs of FQHC Services Provided to Permanent Supportive Housing Tenants

In all of the programs we visited, Medicaid reimbursement was an important source of funding but it did not cover the full costs of services provided by FQHCs in PSH. FQHC clinicians who work in housing settings often have lower levels of productivity compared to those who work in busy clinics, as measured by the number of "billable encounters," because of the added time needed to engage and effectively serve people with long histories of homelessness and multiple health and behavioral health needs. This can make it challenging to sustain partnerships between Health Centers and housing providers if there is limited funding to cover the gap between Medicaid revenues and program costs, particularly as Health Centers face competing demands to deliver clinical services in other settings where staff members may be able to provide care that produces more Medicaid revenues.

2.4. Looking Ahead to 2014: How is the Situation Likely to Change for Federally Qualified Health Centers?

When nearly all homeless people gain eligibility for Medicaid under the ACA, more FQHCs will likely find it feasible to deliver health care services tailored to meet the needs of PSH residents. HCH providers and other FQHCs that are already committed to serving homeless people and other people with complex health and psycho-social challenges will be able to increase the revenues they get from Medicaid, if they can expand their staff and services.

However, the ACA, when fully implemented in 2014, will increase demand for access to primary care services among *all* uninsured low-income Americans. Many newly eligible people have mental health and substance use conditions and many of them have not have had routine access to primary health care or specialty behavioral health care. Given the shortages of both primary care practitioners and psychiatrists, FQHCs will be hard pressed to meet all needs. Moreover, if states do not remove same-day billing exclusions, they will continue to pose a significant barrier to offering comprehensive and integrated services. Health Centers that do not currently have the

capacity to serve chronically homeless people and PSH residents may find it more compelling to respond to other priorities--for example, to focus on maintaining the loyalty of low-income families who have been relying on the Health Center for access to affordable health care, but who will have the option of getting care from other providers when they become insured under ACA.

3. MENTAL HEALTH SERVICES

Given the prevalence of mental illness among chronically homeless people, providing mental health services in a community setting is essential for meeting the needs of chronically homeless people who move into PSH. Nearly every state uses the Medicaid Rehabilitation Option (MRO) to provide Medicaid reimbursement for some community-based mental health services--that is, services provided outside an institutional setting for people with mental illnesses. Because these are optional Medicaid benefits, states vary widely in the scope of covered services and the criteria used to determine who is eligible to receive services.[15]

Federal law also provides flexibility that states can use in determining the types of staff who can deliver services covered under Medicaid's Rehabilitation Option. Licensed Practitioners of the Healing Arts (LPHA) are qualified to provide Medicaid-reimbursed MRO services.[16] States have some flexibility in defining LPHAs for purposes of Medicaid reimbursement, and state policies often include several types of licensed mental health providers, providing more flexibility than the FQHC reimbursement mechanism.

Most states have fairly flexible provisions regarding the qualifications (education, skills) of unlicensed mental health workers who can deliver services under the supervision of LPHAs. In some states, services can be reimbursed when given by peer counselors. This allows agencies to employ staff whose personal experiences (for example, with homelessness or mental health issues) make them effective at providing PSH services.

In many states, MRO mental health services as well as other "specialty mental health services"[17] are financed through "carve-out" arrangements, under which services are administered and reimbursed separately from other Medicaid-reimbursed health care services. The services available under the carve-out are sometimes administered

---

[15] Federal law does not require states to limit coverage of rehabilitation services to those that address mental health conditions, and some states also use MRO to cover other types of rehabilitation services for substance abuse treatment, or services such as physical therapy and occupational therapy. For more information see http://aspe.hhs.gov/daltcp/reports/handbook.htm.

[16] The federal framework governing Medicaid reimbursement for these services is described in the *Handbook: Using Medicaid to Support Working Age Adults with Serious Mental Illness in the Community* at http://aspe.hhs.gov/daltcp/reports/handbook.htm.

[17] The focus of this report is on mental health services covered by Medicaid under the Rehabilitation Option, because these are the services most often delivered in PSH. The term "specialty mental health services" also includes other types of Medicaid-covered mental health services delivered in clinics, including CMHCs, other outpatient or residential treatment facilities, or local acute care hospitals which may provide emergency room care for psychiatric emergencies or short-term inpatient hospitalizations. "Carve-out" arrangements often include this broad array of service locations, providers, and clients, and may also include some pharmacy costs. In addition to these "specialty mental health services" Medicaid may also cover limited mental health services offered by primary care providers or managed care plans, such as prescribing medications for depression or limited counseling services.

by behavioral health managed care plans. Medicaid waivers may allow a government agency or a managed care plan to contract selectively with specific providers, by waiving the program's "freedom of choice" requirements.

In a few states some or all Medicaid-covered services for a broad range of behavioral health needs and conditions including substance use disorders are also included in these carve-out or managed care arrangements. In other states the carve-out or managed care arrangement covers only services for persons with SMI or children who are severely emotionally disturbed (SED), while more limited Medicaid-covered services for persons without SMI/SED may be delivered by other health care providers, and treatment services for substance use issues are administered separately.

Depending on the state, fiscal responsibility for the non-federal share of costs for services provided under a carve-out may differ from cost-sharing for other Medicaid services, which usually falls on states to provide. As a result these benefits may be administered separately by a different government agency (e.g., a county mental health agency) that is responsible for determining which providers qualify to receive reimbursement for covered services.

3.1. Who is Eligible for Mental Health Services Covered Under Medicaid?

Each state establishes its own specific criteria for eligibility for community mental health services. Generally, in order for services to be covered there must be "a need for mental health services for a mental disorder or suspected mental disorder," and the person must meet the first of the following three criteria, plus either one or both of the other two:

1. Diagnosis: a qualifying mental or emotional disorder verified by a diagnosis contained in the DSM-IV or ICD-9-CM. (Each state is likely to publish a list of qualifying diagnoses.) Level of disability and duration of illness also help determine the presence or absence of SMI.

2. Functioning: serious or significant impairment in one or more areas of life functioning, such as basic life and survival skills, self-care, employment or occupational functioning, functioning in school, family or social relationships, use of appropriate supportive community services, etc.

3. Treatment History: prior hospitalization(s) or treatment at some point during the person's lifetime for a diagnosed mental illness in outpatient, residential, or other mental health program.

States may impose additional medical necessity criteria for service initiation, continuing service, exclusion, and service termination. States may also establish systems of "utilization management, including prior authorization ("gatekeeping") or

utilization review for some types of community mental health services--particularly services that are costly or intensive. States set up these criteria and systems with the goal of controlling costs and ensuring that limited resources are used effectively. Eligibility and medical necessity criteria established by states may focus almost exclusively on a diagnosis and symptoms related to SMI, or they may incorporate functional criteria that reflect complexity and impairment related to co-occurring substance abuse disorders, health conditions, and homelessness. The text box gives an example of how Illinois attempts to target the use of expensive Community Support Team (CST) services.

Illinois Eligibility Criteria for Community Support Team (CST) Services

Among other criteria, the person "has tried and failed to benefit from a less intensive service modality or has been considered and found inappropriate for less intensive services at this time," AND exhibits three or more of the following:

- Multiple and frequent psychiatric inpatient hospital readmissions, including long-term hospitalization.
- Excessive use of crisis/emergency services with failed linkages.
- Chronic homelessness.
- Repeated arrests and incarcerations.
- History of inadequate follow-through, related to risk factors, with elements of a treatment plan, including lack of follow-through in taking medications, following a crisis plan, or achieving stable housing.
- High use of detoxification services--two or more episodes per year.
- Medication-resistance due to intolerable side effects, or the illness interferes with consistent self-management of medications.
- Ongoing inappropriate public behavior within the last three months including public intoxication, indecency, disturbing the peace, delinquent behavior.
- Self-harm or threats of harm to others within the last three months.
- Evidence of significant complications such as cognitive impairment, behavioral problems, or medical problems.

The list includes other criteria less relevant to most homeless persons.

Also taken into consideration in determining whether a person meets medical necessity criteria for CST are: chronic homelessness, repeat arrests and incarceration for offenses related to mental illness, and multiple service needs.

3.2. How are Mental Health Services Provided to Permanent Supportive Housing Residents?

All three of the states we visited use the MRO to provide Medicaid reimbursement for a range of services delivered in community settings, including PSH.[18]

---

[18] In some cases, states may use other Medicaid optional benefits, including the Clinic Option or the TCM Option, to reimburse providers for some mental health services. But service-providers who participated in site visits for this project reported that these benefits were generally not being used to reimburse services in supportive housing.

3.2.1. Massachusetts

Massachusetts has long had a MRO carve-out, with most MRO services administered by MBHP as a managed care plan.[19] MBHP receives a capitated premium from the commonwealth and in turn contracts with providers, who are reimbursed for a broad array of therapeutic interventions using unit rates, daily rates, and bundled rates. Programs operating under bundled rates include ACT teams (using a unit rate for each 15-minute encounter). A special Massachusetts pilot program, the Community Support Program to End Chronic Homelessness (CSPECH, described later in this paper), provides a daily rate for community support services that were previously reimbursed under a unit rate for each 15 minute encounter; the daily rate is provided for each day a person is in the program. Daily or bundled rates cover many of the "glue" services that allow multi-service teams to work flexibly and effectively with clients who have complex needs, including people who have been chronically homeless.

Vinfen (Massachusetts)

Vinfen is a large non-profit human services organization providing a range of clinical, housing, rehabilitative, and support services to children, youth, and adults with mental illness, developmental disabilities, and behavioral health disabilities. Homeless clients come to Vinfen only through Massachusetts Department of Mental Health (DMH) referrals. Vinfen serves them under several contracts, including the contract for Medicaid-reimbursed mental health services administered by MBHP.

Vinfen offers a diverse array of community-based and site-based housing and residential support services. Rehabilitative day services include a recovery learning center, a clubhouse (Webster House) offering arts-based rehabilitation, peer support, and education services. Clinical and rehabilitative treatment may be delivered in an office setting or through a mobile team. Vinfen provides assertive community treatment (ACT) programs, including the Program for Assertive Community Treatment (PACT) and Community-Based Flexible Supports, both of which have funding that covers outreach and coordination with clients and treatment team members. Vinfen operates a Safe Haven and uses a housing first model, providing housing subsidies to rapidly engage individuals who have been disaffiliated from care systems. These clinical and rehabilitative programs work with clients on acquiring skills and resources to support independent living, following a plan of care that client and team develop together.

If clients are not Medicaid recipients at the time of referral, Vinfen case managers work with them to gain eligibility for MassHealth either because of poverty or because of disability-based qualification for SSI or Social Security Disability Insurance. Vinfen's homeless clients are then covered for primary and specialty health care services under the MassHealth Medicaid program. Using a combination of unit rates, daily rates, and bundled rates, MBHP reimburses providers for a broad array of therapeutic interventions delivered in hospitals, clinics, and day and residential treatment settings, including team-based services like PACT and daily community support program (CSP) payments for case management services targeted to homeless persons.

Vinfen, described in the text box, is an example of the many providers with whom the MBHP contracts to administer carve-out services.

[19] In addition, the Massachusetts DMH administers some MRO mental health benefits directly rather than through the carve-out administered by MBPH.

3.2.2. California

California uses the MRO to provide Medicaid reimbursement for some of the services in PSH that support chronically homeless people who are seriously mentally ill. Voter-approved state funding through California's Mental Health Services Act (MHSA) provides very flexible, client-centered services through "Full Service Partnerships" (FSPs) that incorporate elements of Evidence-Based Practice (EBP) such as ACT teams, Integrated Dual Disorder Treatment (IDDT), and Motivational Interviewing. In California, the counties are responsible for the non-federal share of Medicaid-covered mental health services, and providers of mental health services must be under contract with the county in order to obtain Medicaid reimbursement. Some California counties have been able to use MHSA funding to leverage Medicaid funding of mental health services under the MRO.

Conard House (San Francisco, California)

Conard House became a Medicaid provider of mental health services more than a decade ago. Medicaid reimbursements cover only about a third of the costs of the supportive services that Conrad House delivers on-site in supportive housing, even when all or most tenants are seriously mentally ill. Conard House provides a robust array of program elements, including treatment and recovery supports, vocational and supported employment, and representative payee services that help tenants pay their rent and manage their limited incomes.

PSH support services staff help tenants access primary care from neighborhood clinics and build skills for wellness and self-management. Conard House, along with similar agencies, finds that histories of trauma are almost universal among chronically homeless and vulnerable people who are in PSH or are candidates for it. Establishing their trust often means learning about the interests and goals of the person and not focusing immediately on mental illness or substance use disorders. Staff members work with tenants to support their efforts to become "emancipated" from the system of care. Conard has begun training tenants and case managers in a Chronic Disease Self-Management Program developed by Stanford University. With training, staff can develop service plans that focus on client goals and priorities and that also meet requirements for Medicaid reimbursement, but this can be challenging, and not all of the time devoted to establishing relationships and starting engagement will necessarily be reimbursed.

MHSA funding must be used to serve persons with SMI who were previously not served (or poorly served) by the mental health system and homeless or in jail. Many were living on the streets or in encampments and often they were *not* high-cost consumers in the county's mental health system prior to enrollment in MHSA services. Although they may have long been disabled by mental health conditions, many have also been disaffiliated from care systems. To serve them, county mental health systems have had to modify their usual centralized "gatekeeper" system that relies heavily on records of prior mental health treatment and psychiatric hospitalization to determine eligibility for services. Two examples from the San Francisco Bay Area (see text boxes) illustrate how Medicaid reimbursement and MHSA funding have been used to serve the chronically homeless population.

Bonita House (Alameda County, California)

Bonita House, a mental health services provider, is home to a FSP team known as Homeless Outreach and Stabilization Team (HOST). HOST's staff do "whatever it takes" to engage adults with SMI and support their recovery. The FSP model that HOST uses incorporates many elements of ACT. The team includes case managers, a peer counselor, a psychiatric nurse practitioner, a physician's assistant from an FQHC, an employment specialist, housing staff, and a supervising social worker plus administrative support. The staff to client ratio is 1:10. The team meets for 90 minutes every day and staff spend 80 percent of their time in the field. A team member is on call around-the-clock for crisis intervention, coaching in relapse prevention, or responding to landlords.

Staff do home visits and accompany clients to appointments and on shopping trips. They offer help in getting access to neighborhood resources and building community-living skills. Some clients are lonely and need or want a safe place to socialize; the HOST office provides some groups, as well as computers that can be used for web-based skills training, through a partnership with Manpower that also offers help finding jobs or internships.

Clinical staff outreach is often done in partnership with other community outreach workers who have built a trusting relationship with the homeless person over a long time. Staff use screening tools and complete assessments in the field, after which they call the county access team to review and get approval to enroll. Because resources are scarce, there is a lot of pressure to ensure that only those with SMI are served in programs funded through county mental health (including MHSA), but Medicaid eligibility is not a criterion used to determine eligibility for services or housing.

Alameda County provides training to support efforts to obtain Medicaid reimbursement for covered services delivered by the HOST team and by other service-providers. The training focuses on ensuring that service-providers understand the definitions of Medicaid-reimbursable community mental health services and the medical necessity (or service necessity) criteria associated with each service. In California, all Medicaid-covered mental health service contacts must be documented with progress notes that include date and duration (number of minutes), location, and a clear explanation of how the service meets the client's mental health needs. For team consultations, only the minutes spent discussing a particular client are billable, and notes must describe the unique contribution of each staff member involved in the discussion.

3.2.3. Illinois

Illinois covers a fairly broad range of services for persons with mental illness under its Rehabilitation Option, usually referred to as "Rule 132." Two Community Mental Health Centers (CMHCs), Thresholds and Trilogy, provide supportive services and coordinate care for their formerly homeless clients with SMI who now live in PSH. HHO also includes a CMHC and offers PSH.

Most clients of Thresholds and Trilogy live in scattered-site housing throughout the community, but these CMHCs also operate some site-based PSH.[20] While Thresholds

[20] The Shelter Plus Care program subsidizes the rent in most of the scattered-site PSH, while SHP grants support the housing and some of the services in the site-based PSH.

and Trilogy have a long history of serving homeless people with SMI and helping them secure and retain housing, recent cuts in state funding, and new limits on Medicaid reimbursement have made it hard to pay for some services. In addition, the mental health-related care they give is not usually integrated with primary health care, although they may be treating the clients' co-occurring substance use disorders. Trilogy recently received a HHS Substance Abuse and Mental Health Services Administration (SAMHSA) grant to integrate its mental health services with primary care and plans to work with Heartland International Health Center to add a primary care provider to one of Trilogy's mental health service sites.

These agencies use a Medicaid-reimbursed CST benefit, under MRO, to serve homeless people and those living in PSH. The CST is made up of at least three full-time equivalent staff, including at least one qualified mental health professional, and, if possible, one person in recovery. The teams have a client to staff ratio of no more than 18:1. Services are available 24 hours a day, 7 days a week as needed, and at least 60 percent of services are provided in a client's home or other community setting, rather than in a clinic or office. Services facilitate illness self-management, development of interpersonal and community-living skills, identification and use of natural supports for treatment and recovery, and plans and strategies for crisis management and relapse prevention.[21]

3.3. Challenges, Obstacles, and Limitations of Medicaid-Reimbursed Mental Health Services

3.3.1. Covered Services and Rules for Documenting Costs Can Be Inconsistent with Service Models

While the MRO is often used to cover rehabilitative and supportive services once a person is on Medicaid, these benefits do not cover the costs of the outreach and extended engagement sometimes required to bring a client into care and maintain the caregiving relationship. For residents of scattered-site PSH, there is usually no reimbursement for services that help people find apartments, advocate with landlords on behalf of homeless people during tenant screening, and negotiate with landlords to resolve disputes or arrange repairs. Furthermore, there may be no way to pay for the time mental health workers spend traveling between clients in different buildings or neighborhoods and for time spent when the client is not home when the service-provider arrives for a visit.[22] While states could potentially use Medicaid's Targeted Case Management (TCM) Option to provide Medicaid reimbursement for some of that effort, the site visits conducted for this project suggested that TCM benefits are limited,

---

[21] For more information about CST and other service definitions, see http://www.hfs.illinois.gov/assets/070107_cmph_guide.pdf.

[22] Some of the services described in this paragraph are potentially Medicaid-reimbursable as optional benefits under federal law, but states may have limited coverage for these services in order to control costs or protect against fraud or abuse, or the reimbursement mechanisms may not be available to the providers who deliver services in PSH.

not well-aligned with MRO services, or not well understood by the providers serving chronically homeless people.

When reimbursement is provided on a fee for service (FFS) basis, most states require detailed documentation and billing by the minute or in 15-minute increments. Even when mental health services are covered through managed care arrangements, the MCO may reimburse the service-providers with which it contracts on a FFS basis. Substantial training and guidance is often needed to build the capacity of PSH service-providers to work with chronically homeless people and tenants to create and amend individual service plans and provide adequate documentation for covered services. Many service-providers who participated in this project's site visits said their staff are frustrated by the time it takes them to meet the requirements that they document each service with case notes and bill by the minute. Staff say these tasks limit their ability to be available for flexible personal engagement and relationship-building with people who are not seeking treatment even though they have a high level of disability.

Sometimes a service-provider engages a tenant several times for short contacts during the same day to establish and sustain a trusting relationship, and help build skills for socialization and independent living. Computer billing systems sometimes reject these as duplicate services, and documenting such activity in a way that supports reimbursement for multiple services during the same day can be challenging. PSH residents may be reluctant to sign off on service plans or other paperwork that is are essential to the providers if they are to get reimbursed for the care they deliver. Many providers observed that policy changes that would give them more flexibility to provide consistent services, including multiple services on the same day, could also lower administrative costs and increase quality.

3.3.2. State Rules May Reduce Funding for Mental Health Services for Permanent Supportive Housing Residents

People with mental illnesses recover, and their needs for supportive services change over time. Adjusting the types and levels of services provided to PSH tenants can be challenging for providers. For example:

- Illinois recently imposed requirements for periodic review to determine whether clients continue to meet criteria for eligibility to receive ACT or CST services. When PSH tenants recover, they may become ineligible to continue receiving the types of services that are most often available in PSH, and relationships between tenants and their service-providers may be disrupted. For providers, this may reduce the only available funding source for mental health services for PSH residents. Some providers may be able to maintain funding by using staff who work in PSH to deliver services to other people with SMI living nearby.[23]

[23] For more information about Illinois Medical Necessity Criteria see http://www.dhs.state.il.us/OneNetLibrary/27896/documents/By_Division/MentalHealth/brittan2/MNCGManualFinal010711.pdf.

- In Massachusetts, Medicaid reimbursement is available for a broad range of living and social skills training, counseling, and therapies in home and community-based settings, which are covered under the MRO if services are related to the client's action plan. However, site visit participants reported that outpatient reimbursement rates in the Medicaid program are very low, and supplemental payments that were once funded through contracted state dollars to outpatient providers to cover collateral care activities have been cut. Some providers in Massachusetts reported that the state has revised rules for Medicaid reimbursement under the MRO to reduce flexibility in developing client action plans and to pay for only "face to face" or "phone" contacts. As a result, costs cannot be recovered for outreach and engagement if the person is not found where expected or for "no shows" in office settings.

3.3.3. Fiscal and Administrative Responsibility May Be Fragmented

When mental health services are "carved out," fiscal and administrative responsibility for mental health or behavioral health services is separate from responsibility for other types of health care. This may limit incentives for policy makers and program administrators to examine the full cost of health care and patterns of health service use that could be improved with better care management or by linking behavioral health services to housing.[24] This is particularly true for people who are chronically homeless, who may be frequent users of hospital emergency rooms or may receive medical or psychiatric care in jail. Engaging these individuals in services in PSH may result in significant savings by reducing the use of health care provided in emergency, inpatient, or institutional settings, but "carve-out" arrangements can limit opportunities to recognize and reinvest these savings in services provided and reimbursed through the mental health system.

In part because mental health services are often separated from other Medicaid-covered health care services under a carve-out arrangement, medical necessity criteria and definitions of covered services often allow for reimbursement of services that focus on symptoms of mental illness or functioning impaired by mental illness, but do not cover services that focus on co-occurring medical or substance abuse related problems. For example:

- Some state Medicaid programs cover mental health services delivered in community settings, but not substance use services, and Medicaid often does not cover the cost of coordinating care and benefits across mental health and substance use treatment services.

- To obtain Medicaid reimbursement for services provided by ACT, CSTs, or other mental health service-providers, in many states there must be clear documentation that connects each service to the client's mental illness and plan

[24] For generic problems with "carve-outs," see W. Joines, J. Menges, and J. Tracey, "Programmatic Assessment of Carve-in and Carve-out Arrangements for Medicaid Prescription Drugs," prepared for Association for Community Affiliated Plans. The Lewin Group. October 17, 2007.

of care to reduce symptoms of mental illness or restore functioning impaired by mental illness. This often means that claims may be disallowed if the progress notes indicate that services focus on problems related to substance abuse, managing a chronic health condition, or treating an acute health crisis that is not clearly related to the diagnosis or symptoms of mental illness.

3.3.4. Similar Services Are Often Not Covered for Vulnerable Chronically Homeless People Without Serious Mental Illness

Outreach workers often encounter chronically homeless people who have very serious health problems--and often co-occurring substance abuse problems, but not SMI. They may have less severe mental health disorders (including depression, anxiety, or trauma) or behavioral or cognitive impairments that result from brain injury, dementia, other physical conditions that produce mental disorders, or developmental disabilities. Some conditions may impair a person's thinking and functioning but are "excluded diagnoses" for purposes of determining eligibility for mental health services, using the criteria established by the state. Programs cannot enroll or serve these people if they rely on funding through Medicaid reimbursement for mental health services. In some states, outreach teams and other mental health providers may be reimbursed for a very limited number of hours of services provided to a person with a suspected mental disorder, to complete assessments to determine if the person has SMI that would meet eligibility criteria for ongoing mental health services, or to respond to acute crises. Outreach workers may try to link people who are not eligible for Medicaid-funded mental health services to other services, but usually cannot follow up.

3.4. Looking Ahead to 2014: How is Coverage for Mental Health Services Likely to Change?

States may use Benchmark Plans to make Medicaid services available to some or all people who become Medicaid beneficiaries in 2014, including homeless people and PSH tenants. Benchmark Plans do not have to include the entire set of services in a traditional Medicaid state plan, but will have to include ten "essential health benefits." Essential health benefits include mental health and substance use disorder services, including behavioral health treatment; ambulatory patient services; emergency services; hospitalization; maternity and newborn care; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

4. INTEGRATED MODELS THAT COMBINE FEDERALLY QUALIFIED HEALTH CENTER AND MENTAL HEALTH FINANCING

Combining the capacity of FQHCs and mental health service-providers and the reimbursement mechanisms available to the two types of organizations can create a more comprehensive and flexible package of services for chronically homeless people. For example, the FQHC reimbursement mechanism may be used to cover services to people who have mental health or substance use problems but do not qualify for specialty mental health services. A psychiatrist or LCSW can deliver those services in the context of comprehensive primary care, and FQHCs can use other sources of funding, including their HRSA grants, to cover some of the costs of care provided to persons who are not enrolled in Medicaid. Conversely, mental health funding under the MRO can be used for services not covered by the FQHC reimbursement mechanism.

4.1. Integrated Models

The communities we visited for this project offered excellent examples of collaboration to deliver integrated primary care and behavioral health care services, both among separate organizations and across programs operated by the same organization. Mental health programs and FQHCs can be co-located programs that operate within the same building but use separate staff, documentation, and reimbursement mechanisms. Staff of co-located programs can consult with one another and make "warm handoffs" to introduce a client to another program operating in the same location. Team-based models may use staff members who are funded separately but work together on a daily basis. Information needed for service planning and care delivery may be shared through integrated electronic records and case conferences, with client permission. Examples we observed during this project are:

- **Chicago.** HHO, an FQHC, has developed a "full continuum" of homeless-oriented services, including outreach and engagement, primary care, mental health services, and service related to substance use disorder. If a person connects to HHO through any of its many "doors" (the HCH clinic or one of several outreach programs) and is willing to accept services of any type, HHO completes an integrated intake assessment. The integrated assessment tool gathers the information needed to determine whether the client meets eligibility and medical necessity criteria for a range of services, each of which has different categorical requirements. The assessment tool "crosswalks" to the rules associated with different types of services or benefits. At a weekly integrated intake meeting, staff review the person's assessment, discuss options for housing and services, and compare them to the person's own stated desires and likely eligibility for benefits that would cover the costs of different options. The

meeting works out an “offer” to the person, with information about waiting times and other relevant facts, and HHO then works with the consumer to find the best fit from what is available.

- **Alameda County and San Francisco.** Bonita House and Lifelong Medical Care in Alameda County and the SFDPH and Citywide Case Management (CCM) in San Francisco have implemented partnerships that integrate the services of an experienced FQHC and an experienced provider of mental health services to serve the same group of people in site-based or scattered-site supportive housing. The FQHC and the mental health service-provider receive Medicaid reimbursement separately. The mental health provider can receive reimbursement for a flexible range of services provided by unlicensed staff (with appropriate training and supervision), but only for persons with SMI and for services and goals related to symptoms of mental illness. The FQHC receives Medicaid reimbursement for medical and psychiatric services, delivered mostly by licensed clinicians, and can get reimbursed for services that address a broader range of health or behavioral health conditions, whether or not a person has SMI. This partnership model is thus able to bridge the gaps in reimbursement rules. Staff members coordinate to deliver integrated care as part of a team, and each provider does what it does best and can get reimbursed for.

  PSH residents throughout San Francisco have access to health services provided by the SFDPH’s HUH clinic, which sees about one-third of San Francisco’s 3,600 PSH tenants each year. In addition to services provided by the HUH clinic, SFDPH contracts with the University of California-San Francisco to operate the CCM program. CCM has several decades of experience providing mental health rehabilitation services reimbursed by Medicaid and participates in programs that target high-users of emergency or inpatient psychiatric hospital services. CCM offers services to supportive housing tenants in 26 buildings. A roving team delivers services to about 125 people every quarter, with a focus on responding to tenants in crisis, and provides services that supplement basic on-site tenant services at the housing sites, including clinical consultation with on-site case managers.

  In Alameda County, Bonita House’s HOST works with Lifelong Medical Care, an FQHC. A primary care provider from Lifelong is co-located at the HOST office and works as a member of the HOST team. She provides primary care to HOST clients, participates in case conferences, and makes home visits as needed. Engagement and relationship-building with the HOST program often begins with attention to health problems, because some chronically homeless people are willing to accept care for their significant health problems but will not to accept a diagnosis of mental illness. Because Lifelong has clinic sites throughout the county, HOST can build primary care relationships that can offer continuity of care as people move from homelessness into PSH.

Case Example of Coordinated Care in San Francisco

Client: Mr. Jones (client's name has been changed) was a 64-year-old Caucasian male who lived in a San Francisco PSH building. He was referred to CCM by the property manager when his hoarding and cluttering behavior had led to his failing the Housing Authority's housing inspection because of safety issues. This meant that he faced potential eviction from the PSH building because he would be unable to pay the rent. The hoarding behavior was related to his diagnosed bipolar disorder and obsessive compulsive personality disorder. In addition, he had diabetes that he did not consistently manage and had received a diagnosis of terminal lung cancer.

Mr. Jones had periods of erratic behavior, irritability, and anger, and frequent conflicts with neighbors. His obsessive compulsive personality disorder also contributed to problems with keeping medical appointments and an inability to make decisions about his cancer-related medical treatment. While confronting end-of-life issues, he was isolated from family and other social contacts, but wanted to reconnect with a son from whom he had been estranged for 20+ years.

The clinical social worker who worked as part of the CCM Roving Team responded to Mr. Jones's situation by:

1. Holding weekly supportive meetings with the Roving Team clinician, who helped him go through his mail to determine items to be discarded or followed up on. He was linked to In Home Support Services (IHSS) to help him clear away clutter in his room.
2. Coordinating with his primary care physician and oncologist to support follow-through with treatment and appointments.
3. Coordinating with his psychiatric providers at a nearby mental health clinic to get him to appointments and monitor and manage his symptoms.
4. Developing a contract with property management that specified the behavior needed to prevent eviction.
5. Providing weekly therapy and support around grief related to end-of-life issues and help finding his son.

Outcomes:

1. Mr. Jones completed surgery, chemotherapy, and radiation treatment for managing his lung cancer and was linked to hospice services before his death.
2. He began taking psychiatric medications regularly, thus stabilizing his moods and consequently his housing.
3. Mr. Jones cooperated with a deep clean/organization of his room. He was able, with the help of IHSS, to discard some belongings so his unit could pass the San Francisco Housing Authority's housing inspection.
4. He reconnected with his son after 20+ years, and the son visited him before he died.
5. Mr. Jones was able to spend his last days in his home as requested, receiving palliative care from the hospice program.

- **Portland, Oregon.** Central City Concern (CCC), which began more than three decades ago to provide clean-and-sober housing to formerly homeless people with substance use disorders, today provides a broad range of engagement, treatment, rehabilitation, recovery support, shelter, and housing services to homeless people. The majority of people served by CCC have co-occurring behavioral and other health conditions. CCC combines services provided under

its FQHC and behavioral health clinic licenses and recently renovated a building where both these services are delivered. The primary care clinic is financed through HRSA grants and FQHC Medicaid reimbursement. Services provided in the behavioral health clinic receive Medicaid reimbursement under an Oregon managed care carve-out, and supplemental FQHC reimbursement is “wrapped around” the behavioral health financing to fill gaps in coverage. To meet separate licensing requirements for primary and behavioral care clinics, the integrated site must maintain separate reception areas. Despite the artificiality of this arrangement, practitioner offices are integrated, and all practitioners use shared medical records.

Housing costs are funded through HUD's Shelter Plus Care and SHP grants, supplemented by Portland City general funds administered by the Housing Authority of Portland. CCC’s broader services rely on multiple sources of funding. Detoxification services, for example, are covered by a combination of federal substance abuse block grant funds, Oregon Health Plan treatment slots, and FFS Medicaid reimbursement for those who have Medicaid benefits because of other disabilities. Despite the organization’s ingenuity in coordinating a diverse range of financing sources, CCC still experiences gaps in coverage for case management services, outreach and engagement services, and “front desk” services in PSH.

4.2. Who is Eligible for Integrated Care?

For homeless people and residents of PSH, eligibility for and access to integrated care depends in part on whether the partnership between an FQHC and behavioral health services takes place within a program that is limited to serving persons with SMI, or in a clinic or program with the capacity and funding to serve a broader population. During site visits for this study we saw both types of collaborative programs. When an FQHC partner helps to add primary care services to a mental health program that provides PSH, services are usually available only to persons with SMI who qualify to receive mental health services (as described in Section 3.1). When behavioral health services are added to and integrated with the services provided in PSH by an FQHC (as described in Section 2), usually the program serves people with a broader range of needs, including those with or without Medicaid eligibility. Depending on conditions attached to funding sources, access to the partnership’s behavioral health services may be available for people with a range of mental health and/or substance use problems, or it may be limited to those individuals with SMI.

4.3. Challenges, Obstacles, and Limitations for Integrated Care

Most states have separate rules governing Medicaid-reimbursed medical care and behavioral health care services, including rules that cover provider qualifications, program sites, record-keeping, and payment mechanisms. While many providers are

making major investments in new electronic health record systems, these systems generally do not offer the capacity to fully integrate information about a client's health, mental health, and substance abuse conditions and services. In part this is because each public agency requires providers to use its own system for electronic billing and documentation of services to obtain Medicaid reimbursement. This is particularly true if mental health services are administered through a "carve-out" arrangement. There is often little or no guidance available for partnerships that integrate the delivery of Medicaid-covered primary care and behavioral health services for the same people, in the same location.

The partnership arrangements described here are generally strong, but some FQHCs would like to obtain Medicaid reimbursement for integrated care, including mental health services, provided by their own staff. While in some communities a single organization operates as both an FQHC and a provider of Medicaid-reimbursed mental health services, FQHC providers in some other communities do not understand how to put in place the complex systems needed for the same provider organization to be reimbursed for some services through the FQHC mechanism and other services through programs that receive Medicaid reimbursement for services that are covered as MRO benefits.

4.4. Looking Ahead: How is Coverage for Integrated Care Likely to Change?

The ACA authorizes expansion of a SAMHSA grant program to help integrate primary care with community-based mental health services. This increase in demonstration sites for behavioral health and primary care integration may create opportunities for more PSH service-providers to deliver comprehensive care to homeless people and PSH tenants.

As states enroll newly eligible people into Medicaid, with the expansion of eligibility under the ACA, and make other changes to health care financing and delivery systems, there may be additional opportunities to provide less fragmented forms of coverage and facilitate partnerships that integrate health and behavioral health services.

5. SUBSTANCE ABUSE TREATMENT

Research on homelessness has found that a large portion of people experiencing chronic homelessness have substance abuse disorders,[25] and this was confirmed by interviews with service-providers in the site visits for this project. There is a growing body of evidence that untreated substance abuse is a significant factor driving the avoidable use of hospital emergency rooms and other costly and ineffective use of health care.[26] In theory, homeless people who have Medicaid coverage because they meet current income and categorical eligibility criteria may receive Medicaid-reimbursed substance abuse treatment services. However, most services that address substance use disorders are covered as optional benefits under Medicaid. Reimbursement for substance abuse treatment services is often limited and may be available only for services delivered in facilities designated as substance abuse treatment centers.

5.1. Who is Eligible?

In most states persons with substance use disorders are not eligible for Medicaid enrollment unless they are part of a group with “categorical” eligibility for another reason. Among chronically homeless people this is most likely to be another disabling health conditions such as SMI, a physical disability or a disabling medical condition. When people who are enrolled in Medicaid also have co-occurring substance use disorders, they may qualify to receive Medicaid-covered substance use services.

5.2. How is Substance Abuse Treatment Provided to Permanent Supportive Housing

Service-providers working in PSH help tenants with problems related to substance use, but they rarely receive Medicaid reimbursement for these services. PSH case managers work to motivate tenants to recognize and seek help for substance use problems and to achieve recovery goals. They connect tenants to other programs that offer treatment services.

Most PSH service-providers offer individual counseling and plenty of encouragement for residents to pursue treatment, and they provide ongoing coaching

---

[25] See for example http://aspe.hhs.gov/hsp/homelessness/symposium07/caton/ and http://100khomes.org/sites/default/files/images/100khomes_1yr_report_FINAL.pdf. In a population-based Philadelphia study of chronically homeless adults 56 percent had both a SMI and a history of substance abuse treatment (Psych Services, Nov 2010); 22 percent of more than 18,000 homeless individuals living on the streets surveyed as part of the 100,000 Homes Campaign are living with tri-morbid conditions, meaning a serious medical condition and a SMI and a substance abuse disorder.

[26] For example see http://www.dshs.wa.gov/pdf/ms/rda/research/11/119-31.pdf and http://www.dshs.wa.gov/pdf/ms/rda/research/11/120.pdf.

and support to help tenants achieve recovery goals, but they have limited capacity to provide substance abuse treatment services directly as part of the on-site services they deliver. We did not find any examples during site visits of Medicaid reimbursement for services delivered on-site in PSH that explicitly focus on problems related to substance use disorders. Alcoholics Anonymous/Narcotics Anonymous or recovery support groups are often available, but they are not supported by Medicaid reimbursement.

Residents of PSH who are FQHC clients may receive some Medicaid-reimbursable services through their FQHC that address substance abuse problems. Services may include motivational interviewing and counseling from clinical social workers or psychiatrists.

Mental health providers that are not FQHCs often try to offer services that integrate treatment for co-occurring mental health and substance abuse disorders, but find themselves hard pressed to cover the cost. Agencies that are primarily substance abuse treatment providers may find it difficult to serve people with more severe mental health issues, while some agencies that are primarily mental health providers may limit themselves to people with "light" substance abuse if they are not licensed to provide substance abuse treatment for which they can get reimbursed. Thus some mental health providers are willing to help people who are already clean-and-sober to maintain their sobriety, but they may have a harder time working with active users.

Illinois. The state's Medicaid program provides support for substance abuse treatment through the Department of Human Services' Division of Alcoholism and Substance Abuse (DASA). DASA administers funding from federal block grant and state programs, under which it issues contracts for treatment for substance use disorders. DASA also certifies providers who may then receive Medicaid reimbursement for covered treatment services. DASA is supportive of the harm reduction approach used by many PSH providers, and people housed in settings that follow a harm reduction model may receive substance abuse treatment in DASA-licensed facilities without a requirement for abstinence. All services paid for with DASA's state funding or Medicaid reimbursement must be delivered by a provider with a DASA contract, in a physical space licensed by DASA. For a number of years, DASA has used state funding to give grants to licensed providers to serve people with substance use disorders who do *not* have Medicaid. However, in March 2011 the Illinois governor announced a proposal to cut these funds from the state budget.

5.3. Challenges, Obstacles, and Limitations Related to Medicaid Coverage of Substance Abuse Treatment

5.3.1. Medicaid-Reimbursed Substance Abuse Services Cannot Be Delivered On-Site in Permanent Supportive Housing

Medicaid reimbursement for substance abuse treatment services is frequently limited by state policy to services that are provided in particular types of outpatient

clinics or licensed/certified treatment facilities. There is often no reimbursement mechanism designed to pay for counseling or treatment services that address substance abuse problems in the context of a home visit, a visit with a primary care provider, or care provided by a multi-disciplinary team that engages and provides community support for people with co-occurring physical and behavioral health needs.

In some PSH buildings, particularly single room occupancies (SROs) in which all tenants formerly were homeless, so many residents have substance use disorders that it can be a challenging environment for those who are in early stages of recovery and trying to stay clean-and-sober. Many PSH service-providers would like to be able to offer more services to address substance abuse and support recovery, but Medicaid reimbursement is not available to support delivering these services in a housing setting. When Medicaid reimbursement is available for substance abuse treatment services provided by organizations that also deliver services in PSH, usually the substance abuse treatment services must be provided in a separate location that has been licensed or certified as a treatment program.

5.3.2. Substance Abuse Treatment Usually Is Not Consistent with a Harm Reduction Model or with Integrated Care

PSH service-providers find it difficult to link residents to off-site treatment services that are responsive to their needs. PSH supportive services staff members make referrals to detox or other treatment services available in the community, but few of these are willing to treat people who are not ready to commit to sobriety. Medicaid-reimbursed substance abuse treatment services generally must be provided in programs that are more highly structured than the flexible, client-centered services delivered in supportive housing.

5.3.3. Licensing and Funding Mechanisms for Substance Abuse Treatment Are Not Integrated with Other Types of Treatment

State-defined policies and procedures for provider qualifications and licensing, service definitions, service plans, documentation, and billing for Medicaid-covered substance abuse treatment services are often completely different from the policies and procedures for reimbursing other Medicaid-covered services for mental health or medical conditions, despite the fact that many people have co-occurring conditions.

The situation in **Illinois** illustrates some of the issues that providers have in using Medicaid to pay for services that address substance abuse problems. We heard the most about Medicaid coverage for substance abuse treatment in Chicago, along with some of the challenges. Becoming a DASA-licensed provider in Illinois takes substantial time and effort, with requirements that keep most agencies serving chronically homeless persons from pursuing the license. Even after an agency *has* become a DASA-licensed provider, it must operate as a licensed facility for two full years before it is eligible to receive Medicaid reimbursement.

In Illinois, as in many other states, DASA and DMH have different requirements for just about everything: timeframes for treatment planning and follow-up, allowable treatment types, amounts and duration of treatment, reporting, and other aspects of care. This makes it especially difficult for a program to serve chronically homeless people with multiple disabling conditions.

DASA funding covers care delivered in DASA-licensed spaces, while DMH coverage for mental health services under the state's Rule 132/MRO is heavily oriented toward services delivered in the community, in people's homes or in neighborhood locations. DASA's *model* of care includes coverage for outreach and early intervention services, but in reality virtually all the DASA funding goes for facility-based care. DMH, on the other hand, *allows* care to be delivered to Medicaid recipients in many locations, but DMH does not have any way to cover outreach and engagement unless the person is already on Medicaid. In recent years, DMH used state resources to pay for outreach and engagement to non-Medicaid recipients, but that money is no longer available.

About 10 years ago, HHO developed an integrated assessment and service planning tool for the HHO target population of homeless people with two or more chronic and disabling conditions. DASA-supported substance abuse treatment may be delivered in the same space where mental health services are delivered, as long as the space is licensed by DASA; this is what happens in HHO's Resource Center. The agency must maintain meticulous records showing who delivers what care to whom, so the right agency can be billed and claims will not be denied. When PSH residents need and want substance use-related services, they must go to HHO's Resource Center to get them, while staff offering mental health services may come to where the clients live.

Other agencies in Chicago's homeless assistance network also serve people with co-occurring mental illness and substance use disorders, but very few have a DASA facility license, so they cannot offer substance abuse treatment. Thresholds, a CMHC in Chicago, provides IDDT and raises money, with increasing difficulty, from sources other than DASA or Medicaid.

5.4. Looking Ahead to 2014: How are Services for Substance Abuse Likely to Change?

Much uncertainty exists about the scope of substance abuse treatment services that Medicaid will cover for newly eligible people in 2014. An additional issue is the implication of requirements for "parity" between benefits for treatment of substance abuse disorders and medical and surgical benefits, which are pending promulgation and testing. Guidance and regulations from CMS will be forthcoming, but Benchmark Plans must include ten "essential health benefits" which include mental health and substance use disorder services, including behavioral health treatment, rehabilitation, and habilitation.

In the current fiscal climate, many states are spending less on substance abuse treatment. The availability of Medicaid reimbursement for alternative treatment services currently funded by state resources or federal block grants may free up some of those resources to pay for types of recovery support services that are not covered by Medicaid.

For some of the people who will be newly enrolled in Medicaid, substance abuse will be found to have a significant impact on other health conditions for which treatment will be reimbursed by Medicaid, including the avoidable use of hospital emergency rooms and, ambulances. For these Medicaid enrollees, Medicaid state programs or Medicaid managed care plans may consider covering substance abuse treatment as a strategy for reducing costs. However, health care costs will be relatively low for people who have substance abuse problems without co-occurring serious medical conditions or mental illness,[27] and this may discourage the use of resources for improving access to substance abuse treatment. Thus, Medicaid coverage and other sources of funding for substance abuse treatment services may continue to be limited.

[27] In the Philadelphia study (Poulin et al., 2011, *op. cit.*), 86 percent of chronically homeless people in the bottom quintile of public costs had a history of substance abuse treatment but no diagnosis of SMI. Health costs were not included in this analysis, which could leave out a substantial segment of costs for this population. Costs of ambulances, emergency room care, hospitalizations and detoxification or sobering center services for chronically homeless people with serious alcohol problems (chronic public inebriates) can be very high. In other communities, a focus on the most frequent users of costly crisis care has led to the identification of people with serious and often untreated substance abuse problems, for whom it may be very cost-effective to reimburse services in PSH as an alternative to paying for repeated hospitalizations and emergency room visits. However, costs of health care have been very low for a large group of chronically homeless people with substance abuse problems, for whom public services expenditures primarily reflect costs of shelter, food stamps and General Assistance. (See *Where We Sleep* report--Flaming et al., 2009. Available at http://www.economicrt.org/summaries/Where_We_Sleep.html.)

6. HOME AND COMMUNITY-BASED SERVICES

Medicaid-covered HCBS may be available under an HCBS waiver (1915c) or they may be optional HCBS services covered without a waiver under a Medicaid SPA (1915i). HCBS are intended to offer alternatives to institutional care for people with disabling health conditions. The Kaiser Commission on Medicaid and the Uninsured reports that the national percentage of Medicaid spending on HCBS more than doubled from 1998 to 2009, reflecting a growing interest among policy makers, government officials, and health care providers in responding to the wishes of consumers and family members to support the ability of seniors and people with disabilities to continue living in the community as an alternative to nursing homes and other forms of institutional care.[28]

HCBS waiver services may include home-based nursing, case management, homemaker services (to prepare meals and assist with household chores), and other services that allow people who are very frail or disabled to live in their own home or apartment. These services can supplement the level of supportive services provided in most PSH, making it more appropriate for very vulnerable chronically homeless people, particularly older people and those with severe mental illness or disabling physical conditions.

6.1. Home and Community-Based Services (1915c) Waiver Services

States may operate several different HCBS 1915c waiver programs, each designed to target different groups of people based on age, diagnosis, or condition. States may also receive a waiver of Medicaid's "statewideness" requirements and offer some HCBS waiver services in a particular jurisdiction or region of the state or operate statewide but set a cap on the number of people who may enroll in a waiver program. HCBS 1915c waiver programs are intended to serve people who would otherwise need and be eligible to receive care in a nursing home or institutional setting.

In many states, a significant number of non-elderly people with disabilities, often adults with SMI, are in nursing homes.[29] Many states are working to provide supportive housing as an alternative to nursing home care. These efforts have two potential motives: (1) to reduce Medicaid spending for long-term care; and (2) to comply with requirements to offer people with disabilities the opportunity to live in integrated settings

---

[28] Kaiser Commission on Medicaid and the Uninsured. "Medicaid Home and Community-Based Services Program: Data Update." December 2011.

[29] See A. Pathania, "Nursing Homes in U.S. Register a 41% Increase in Occupancy." March 23, 2009. Data analysis done by the Associated Press using data provided by CMS, http://topnews.us/content/24540-nursing-homes-us-register-41-increase-occupancy. This finding is cited in the report titled *The State of Housing in America in the 21st Century: A Disability Perspective* from the National Council on Disability, submitted to the President in January 2010.

in the community, consistent with the requirements of the Americans with Disabilities Act and the U.S. Supreme Court's 1999 *Olmstead* decision.

6.2. Home and Community-Based Services Option/State Plan (1915i) Services

Recent changes in federal law[30] allow states to provide HCBS services, without a waiver, as optional benefits by making a Medicaid SPA. The purpose of 1915i is to expand access to HCBS to persons with disabilities who are not at an institutional level of care. Therefore, states that want to add this optional benefit must establish needs-based criteria that are *less* stringent than the criteria for institutional services. However, states must provide statewide coverage for these optional services and cannot set limits on the total number of people who can receive these services. This makes it difficult for many states to balance the goal of obtaining FFP through Medicaid with the need to control their own Medicaid budgets.

Service-providers and advocates for homeless people and people with disabilities have explored using the authority provided by 1915i to support Medicaid reimbursement for HCBS services in supportive housing. However, at the time of the site visits conducted for this project in 2011, no states had amended their Medicaid State Plans to provide coverage for these optional benefits with needs-based service criteria that would be likely to target chronically homeless people or PSH residents.

The first state to do so is Louisiana, which has submitted and received CMS approval (in December 2011 and January 2012) for several SPAs for waivers and new optional benefits as integral parts of major changes Louisiana is making to its behavioral health system. One SPA adds HCBS benefits covered under the 1915i option. Covered services related to mental illness, addictions disorders, and co-occurring disorders include services that will be linked to housing assistance for people with disabilities who have been homeless, as well as people who need support to live in the community instead of in institutional settings. Services linked to PSH are described in more detail in Section 6.4.

6.3. Who is Eligible for Home and Community-Based Services

In PSH for chronically homeless people it is likely that some tenants meet clinical needs-based eligibility criteria for HCBS, while other tenants who are less disabled may not be eligible to receive these services.

All people served by 1915c waiver programs must meet service criteria equivalent to the criteria used to determine eligibility for institutional care in a hospital nursing

[30] The Deficit Reduction Act of 2005 added Section 1915(i) to the Social Security Act, which was amended by the ACA of 2010.

facility, nursing home, or similar level of care. While these criteria vary significantly from one state to another, they take into consideration the type and severity of functional limitations, including needs for assistance in activities of daily living (ADL) and instrumental activities of daily living (IADL),[31] *and/or* needs for medical and nursing care. It is not necessary for a person to *be* institutionalized or staying in a nursing home to qualify for HCBS services, but a formal (independent) assessment process is required to determine that a person meets the applicable criteria for institutional care or HCBS waiver services.

As described in Section 6.2, the purpose of 1915i is to expand access to HCBS to persons with disabilities who are not at an institutional level of care, so the needs-based criteria that states establish for these services are *less* stringent than the criteria for institutional services.

6.4. How Can Home and Community-Based Services be Provided to Permanent Supportive Housing Residents?

For the most part, people living in institutional settings are not homeless, although a growing number of older and vulnerable homeless adults are entering nursing homes or other long-term care facilities, often after a period of inpatient hospitalization for an acute medical and/or psychiatric crisis.

North Carolina provides an example of how 1915c waivers are being used in PSH. The state has a partnership between its Housing Finance Agency and HHS that generates hundreds of housing units supported by rent subsidies for people with disabilities. Residents of this housing receive case management and mental health services from community-based service-providers. Some of these services are financed through a 1915c HCBS waiver. Although many residents of these supportive housing units were not homeless when they moved in and may have no history of homelessness, many others came from homelessness--which makes the units they occupy PSH in the nomenclature of homeless service systems.

In **Chicago**, the Chicago Housing for Health Partnership Study,[32] which enrolled homeless people hospitalized for a chronic medical condition, found that 19 percent of the intervention group and 27 percent of the usual care group had at least one stay in a nursing home during the 18-month follow-up period. The intervention group that was offered respite and PSH had more than 40 percent fewer total days in nursing homes,

[31] ADLs include eating, bathing, dressing, toileting, transferring (e.g., from a bed to a chair), and maintaining continence. IADLs include medication management, money management, light housework, laundry, meal preparation, transportation, grocery shopping, and using the telephone.

[32] See http://www.aidschicago.org/housing-home/housing-a-health-network.

compared to the usual care group.[33] These homeless people would presumably meet service necessity criteria for HCBS waiver services.

In **San Francisco**, the Department of Public Health gives priority for admission to its long-term care facility, Laguna Honda, to people who are homeless or who cannot be discharged from a hospital because they do not have a place to live and would thus become homeless. Again these formerly homeless people likely would meet the criteria for HCBS services in PSH. SFDPH currently is attempting to obtain a 1915c waiver to provide the resources to pay for services in PSH that would help people move out of Laguna Honda and live in the community or avoid the need for nursing home care for very disabled homeless people (see text box).

As described above, the State of **Louisiana** worked with CMS to obtain approval of a Medicaid SPA to provide optional HCBS (1915i) that will include ACT and other team-based models of care to PSH tenants with mental illness or other disabling health conditions. Technical assistance is being provided to help PSH service-providers meet requirements to become qualified as Medicaid service-providers and develop the administrative capacity to obtain Medicaid reimbursement. The expectation is that Medicaid reimbursement will cover the full range of services currently funded through state contracts, including outreach and engagement and the “glue” functions such as integrated team meetings and care coordination.

6.5. Challenges, Obstacles, and Limitations of Home and Community-Based Services

While it would appear that state efforts to enable people with disabilities to live in non-institutional, community-based settings should align with efforts to use PSH to end homelessness for people with poor health and high levels of disability, often that is not the case.

6.5.1. Separate Service-Providers, Advocates, and Government Organizations

Most of the programs and categorical funding streams used to serve homeless people are separate and distinct from the programs designed to support de-institutionalization, and the resources of the homeless assistance system have been focused on serving people living on the streets or in emergency shelter. In many communities, separate groups of advocates and service-providers, and often separate groups of government officials, work on behalf of the different populations to create housing opportunities and figure out how to finance and deliver support services linked to housing. While the housing and support needs of people are similar, programs,

[33] Basu, A., Kee, R., Buchanan, D., and Sadowski, L. (2011). Comparative Cost Analysis of Housing and Case Management Program for Chronically Ill Homeless Adults Compared to Usual Care. *Health Services Research*, doi: 10.1111/j.1475-6773.2011.01350.x.

policies, and financing mechanisms have often been developed on parallel but distinct and sometimes competing tracks.

6.5.2. Focus on Living in Integrated Settings May Appear at Odds with the Program Models of Some Permanent Supportive Housing

Legal and policy advocates for de-institutionalization, as well as many people with disabilities and their family members, have placed a high priority on providing opportunities for people with disabilities to live in *integrated settings*--that is, the settings that are not only for people with disabilities. They have often been strong advocates for scattered-site models of supportive housing, or models in which a few supportive housing units are integrated into affordable housing developments in which most of the housing units are not designated for homeless people or other people with disabilities. Supporters of using Medicaid-financed HCBS to expand the availability of services linked to housing for people with disabilities are concerned that these resources not be used to sustain or re-create residential settings that resemble institutions. In April 2011, CMS published a Notice of Proposed Rule-Making that reflects these concerns and conveys expectations about the delivery of services financed through HCBS waivers in home and community-based settings.[34]

Generally the goals that relate to community integration are shared by advocates, service-providers, and housing developers who have been working to create and sustain PSH. Exhibit 1 summarizes some of these areas of agreement, based on criteria articulated in the CMS Notice and the definition of PSH "fidelity" contained in SAMHSA's EBP KIT,[35] as well as standards of quality developed by the Corporation for Supportive Housing.[36] These values and practices were reinforced by the PSH sites we visited and others we learned about for this project.

However, some organizations and policy makers working to reduce chronic homelessness are reluctant to target the available supply of housing units to groups *other than* the most vulnerable homeless people, particularly given the time and level of effort required to assemble the financing and secure approvals for a new supportive housing project. When they build or rehabilitate apartment buildings for PSH, homeless service-providers and housing developers often want to maximize the number of these units that are available to get people off the streets. As a result, in many apartment buildings that have been developed as PSH, all or most of the units are designated for people with disabilities who are homeless.

---

[34] See http://www.gpo.gov/fdsys/pkg/FR-2011-04-15/pdf/2011-9116.pdf.

[35] See http://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4510.

[36] See http://documents.csh.org/documents/Quality/SevenDimensionsQualityIndicatorsWEBFINAL.pdf.

EXHIBIT 1. Commonalities in PSH and HCBS Housing Standards	
Home and Community-Based Settings/ Permanent Supportive Housing SHOULD Have These Features…	**… and NOT be located in a building/facility that provides institutional or custodial care … and NOT have the characteristics of an institution, such as**
• The person has a lease. • Setting is an apartment or housing unit with individual living and sleeping area, and usually has private bathroom and kitchen. • People can choose whether to share a living arrangement and with whom. • People have keys and can lock their own apartments and come and go as they choose. • They are free to receive visitors and leave at times and for durations of their choosing. • People can remain where they live as they age and/or support needs change. • Access to the greater community is easily facilitated based on the individual's needs and preferences. • People can interact with people without disabilities to the fullest extent possible, and can access community activities at times, frequencies, and with people of their choosing. • If the plan is shared with the landlord, or the housing provider is also the service-provider, compliance with the tenant's service plan is not a condition of the lease. • People have choice in their daily living activities, such as eating, bathing, sleeping, visiting, and other daily activities.	• Segregated from the larger community. • Regimented meal and sleep times. • Limits on visitors. • Lack of privacy. • Limits on the person's ability to engage freely in community activities.

While scattered-site PSH using tenant-based rent subsidies and mobile services offer one option for people to live in integrated settings, some PSH providers point out that just placing a disabled person in scattered-site housing is not enough to assure "integration." Without adequate supports, people may end up isolated and lonely. Tales of people drifting back to hover over their case worker's desk, where at least there is company, are too common to ignore. Site-based PSH can be effective for those who need around-the-clock coverage of a front desk to respond to crises or problem behaviors and control the flow of visitors to the building. Site-based PSH also offers opportunities for peer support and participation in a "self-help" community of people who have shared experiences.

Negotiating a 1915c Waiver: San Francisco

Laguna Honda Hospital is a large, county-operated skilled nursing facility that serves many homeless people with complex, disabling health conditions. Since 2007, the SFDPH has been working with California's Department of Health Care Services (DHCS) to design and get CMS approval for a 1915c waiver to finance some of the services provided in PSH to people who have been discharged or diverted from this hospital. The California Legislature authorized the waiver, provided that San Francisco would cover the non-federal share of costs, and CMS received the waiver application in June 2010. SFDPH wants to establish a more flexible reimbursement mechanism to pay for the person-centered services that support community-living for people with high levels of disability who would otherwise be living in Laguna Honda Hospital or on the streets.

Working with state Medicaid (Medi-Cal) officials, SFDPH established a three-tiered rate structure to pay for services to PSH tenants whose conditions would meet criteria for admission to Laguna Honda or another skilled nursing facility. SFDPH hoped that these rates would be paid daily and used flexibly for "wraparound services" provided by nurses and case managers. (The rates were first set at $110, $80 and $55 per day, depending on the level of functioning and need for medical and behavioral health services.) Program managers had hoped that daily rates would significantly reduce administrative costs of documentation and billing, while paying for staff whose costs the FQHC billing mechanism will not reimburse. This may not be possible, however, because of requirements associated with documenting San Francisco's Certified Public Expenditures that will provide the match for FFP through Medicaid. Instead, the rates will be used to make interim payments. These will have to be reconciled with cost reports later, and will also need to be supported by time studies that determine the actual costs for staff time to provide covered services to PSH tenants who meet waiver eligibility criteria.

The SFDPH is still working with the state and CMS to gain approval of the waiver and develop an approach to payment that will be feasible and meet applicable requirements. The process has taken several years. The state and federal staff working with the SFDPH have expressed misgivings about whether some of SFDPH's PSH is consistent with an evolving interpretation of home and community-based housing. State Medicaid program officials have informed SFDPH that waiver services cannot be provided in buildings that do not offer tenants private bathrooms or cooking facilities, which would exclude some renovated SRO buildings (formerly residential hotels), and that regional CMS or DHCS officials will have to inspect and approve every PSH site in which waiver services will be delivered.

A significant number of new supportive housing development projects are integrating PSH units into affordable housing or mixed-income developments that serve other low-income people, with and without disabilities, and sometimes with a range of incomes.[37] PSH service-providers help tenants explore and use neighborhood and

[37] There is growing interest among policy makers, funders and non-profit housing developers in models that integrate PSH units into affordable housing developments. In these developments, PSH units are usually no more than 25 percent of the housing units. In January 2011, President Obama signed the Melville Act, which reforms HUD's 811 housing program for people with disabilities. Among the reforms are provisions that would commit project-based rental assistance to help create integrated supportive housing for extremely low-income people with disabilities. No more than 25 percent of units in a housing development receiving these funds may be used for PSH or have an occupancy preference for persons with disabilities. This new 811 approach requires a partnership between the public housing agency and the state Medicaid agency. For more information see http://tacinc.org/downloads/Section811%20Legislation/Summary%201-7-11.pdf.

community resources, including stores, libraries, public transit, and recreational facilities. Another approach to community integration is to have PSH buildings include ground floor commercial spaces occupied by grocery stores or other neighborhood-serving businesses and meeting rooms that are made available for neighborhood organizations, helping PSH tenants connect with their neighbors.

Establishing Policy for HCBS: Illinois

Many people in Illinois are in Institutions for Mental Disease (IMDs). A very recent consent decree (Williams) obliges the state to "assess" each IMD resident for capacity, and "alert" the person to opportunities to live in less restrictive settings in the community. Illinois is also facing lawsuits related to non-elderly people living in nursing homes, many of whom have multiple medical conditions and complications of substance abuse and/or mental illnesses. Some were homeless before entering the nursing home and may have been discharged to a nursing home after a hospital stay because they had nowhere to go. The state faces considerable pressure to see how many of each group can live in community settings with HCBS that can be reimbursed through Medicaid.

There is also growing concern in Illinois about the large number of people with mental health and/or substance use disorders who fill many medical-surgical beds in a few hospitals. Their average lengths of stay tend to be longer than those of other patients because the hospitals have nowhere to which they can discharge patients safely. Homeless patients discharged without a place to live cannot receive adequate follow-up care, and end up cycling back into the hospital again.

The Williams consent decree is pushing the state to increase the availability of HCBS linked to housing. These developments could provide new opportunities for the state to expand the use of benefits such as ACT and CSTs or to adopt more-flexible funding for services that help people with complex health problems live in community settings. Several state officials consider that the current benefit definitions are too fragmented and that it may be possible to achieve savings that will offset the costs of new or expanded benefits, if people can receive services at home or in the community rather than high-cost Medicaid-funded or state-funded care in IMDs or hospitals and nursing homes.

The state's efforts to meet the terms of the consent decree are complicated by a provision in at least one settlement that defines supportive housing (for people moved from an IMD or nursing home) as housing in which no more than 25 percent of the units are for tenants with disabilities.

An alternative to this strict definition is reflected in the fidelity model adopted in SAMHSA's EBP KIT for Supportive Housing, which includes integration as one of several dimensions of fidelity. It emphasizes offering people choices, which would include: (1) scattered-site housing, (2) supportive housing in mixed-use buildings or apartment complexes that include both PSH and non-PSH units, and (3) buildings dedicated to PSH.

The court monitor for the Williams decree has been holding meetings to consider the pros and cons of various housing options, but for now the state must attempt to create supportive housing based on the narrow definition contained in the settlement. In much of the current stock of site-based PSH, more than 25 percent of units are set-aside for people who are homeless and/or have SMI, thus limiting the opportunities for many current PSH providers to provide housing that will meet the conditions of the consent decree settlement or to use financing mechanisms that may be created to achieve the goals of the consent decree.

6.5.3. Developing State Policy on Home and Community-Based Services and Negotiating a Medicaid Waiver Can Be Very Difficult

Two examples, one in San Francisco and one in Illinois, illustrate just how complicated it can be to use Medicaid waivers or SPA to take advantage of HCBS (see text boxes).

6.6. Looking Ahead to 2014: How is Home and Community-Based Services Likely to Change?

A number of provisions in the ACA provide new or expanded opportunities for states to use Medicaid to finance HCBS for people with disabilities, including enhanced Medicaid matching payments, demonstrations, and new state plan options.[38] States may be able to develop more unified or consistent approaches to creating and financing services in permanent housing for people with a range of disabilities, including those who have experienced prolonged homelessness, as well as those who have been institutionalized or are at risk of institutionalization.

---

[38] A full description of the ACA provisions related to HCBS is beyond the scope of this report. More information about some of these provisions is contained in a report from the National Academy for State Health Policy, "Implementing the Affordable Care Act: New Options for Medicaid Home and Community Based Services," October 2010. Available at http://www.nashp.org/sites/default/files/LTSS_SCAN-FINAL-9-29-10.PDF.

7. MANAGED CARE

States are increasingly relying on managed care approaches to finance and deliver health care and behavioral health services to people enrolled in Medicaid. Under a managed care approach, states provide capitated financing to Managed Care Organizations (MCOs) that then contract with health care providers under arrangements intended to reduce costs and increase the quality of care. The Kaiser Family Foundation reports that the number of Medicaid beneficiaries enrolled in managed care nearly doubled between 1999 and 2008, rising to 71 percent of all Medicaid beneficiaries.[39]

Medicaid managed care began in many states with a focus on enrolling children and families. However, a growing number of states now allow people with disabilities to enroll in managed care plans, and some states require this enrollment. As discussed earlier in Section 4 (mental health services), in most states managed care arrangements for medical care are separate from arrangements for managed behavioral health care, administered by different MCOs, and delivered by different provider networks with separate payment systems.[40]

The implementation of Medicaid managed care often is accomplished through a waiver of some Medicaid rules, including a waiver of “freedom of choice” requirements, allowing the MCOs to contract with a limited set of providers. States generally provide some “wraparound” reimbursement for services provided by FQHCs, in addition to the payment provided to the FQHC by the MCO.

All three of the states where site visits were conducted for this study are in some stage of implementing managed care for mental health services. In California and Illinois, mandatory enrollment in Medicaid managed health care for people with disabilities is just beginning, so the implications for financing and delivering care for chronically homeless people and PSH residents are not yet clear.

In Massachusetts, most Medicaid benefits are administered through managed care delivery and financing systems, with a separate managed care arrangement (and separate MCOs) for some behavioral health services.

---

[39] See http://www.kff.org/medicaid/upload/8046.pdf.

[40] Frequently people who are “dual-eligibles,” enrolled in both Medicaid and Medicare, are not required or permitted to enroll in Medicaid managed care. States may exclude or exempt some groups of particularly vulnerable people with disabilities or very costly or life-threatening illnesses from the requirement to enroll in Medicaid managed care.

7.1. How Does Managed Care Deliver Services Linked to Permanent Supportive Housing

Capitated financing and the quality or performance standards included in many managed care contracts change the financial incentives for health care providers. If reimbursement is no longer provided on a FFS basis for hospitalizations and emergency room visits, this creates incentives for the MCO or the network of health care providers under contract with the MCO to improve their coordination and management of health and behavioral health conditions to reduce use of these costly services and provide more cost-effective interventions. Under managed care arrangements, MCOs may be able to offer services that would not otherwise be covered as benefits under a state Medicaid plan, if these are effective substitutes for more costly covered services.[41]

During site visits and through supplementary contacts with programs in other parts of the country, we learned about a number of managed care arrangements:

- **In Massachusetts, t**he behavioral health carve-out managed by the MBHP (the carve-out's MCO) has the flexibility to identify special need population cohorts and create special contracts with providers to cover their needs. A recent example of a specially-focused program is the CSPECH, in which MBHP collaborates with the Massachusetts Housing and Shelter Alliance. CSPECH is a demonstration that has expanded through MBHP contracts to fund nine partnerships with community organizations around the state to serve a total of 300 chronically homeless people with mental health and substance abuse problems who qualify for enrollment in MBHP-funded services.

  One of the CSPECH organizations, the BHCHP, provides a CSP for people experiencing chronic homelessness who are Medicaid-eligible. All have multiple chronic conditions and were identified as high-risk/high-user Medicaid clients. The program serves approximately 24 people, although more than 200 BHCHP clients would qualify for the program. Program goals are to stabilize people in housing and manage their medical and support needs, saving money on uncoordinated medical care to pay for supportive and case management services. Program elements include home care services, case management, and medical and behavioral health services, all covered by Medicaid. Housing subsidies are provided by HUD Housing Choice Vouchers.

- **Pennsylvania's** managed care behavioral health carve-out arrangement has allowed counties to achieve savings by providing community-based services that reduce the use and costs of inpatient hospital and other high-cost care. Single-county or local behavioral health managed care consortiums in nearly 50 counties have achieved savings that they been allowed to retain and devote to

---

[41] For more discussion of managed care rate-setting and "in lieu of" or substitute services, see page 15 of CMS guide "Providing Long Term Services and Supports in a Managed Care Delivery System." http://www.pasrrassist.org/sites/default/files/attachments/10-07-23/ManagedLTSS.pdf.

funding supportive housing for Medicaid enrollees under a cooperative arrangement with the Pennsylvania Housing Finance Agency. Funds have been used to leverage capital and operating/rental resources, one-time move-in expenses, and for supportive services. More than 3,000 people have benefited from these arrangements since 2008.

7.2. New Arrangements for Managed Care for Residents of Permanent Supportive Housing

In **Louisiana,** the state has selected a MCO that is responsible for administering its new behavioral health carve-out. Included in covered services are services to people in PSH or eligible for PSH. Negotiations are under way on the level of funding that will be provided.

In **California**, for more than a decade most Medicaid-reimbursed mental health services, including psychiatric hospitalizations and community-based mental health services, have been administered through county-level managed care arrangements. California is now moving to require nearly all disabled Medicaid beneficiaries in the state's urban counties to enroll in Medicaid managed care plans for their medical care, under the terms of a recently approved waiver.

In **Illinois,** the state legislature enacted a Medicaid reform law in early 2011, mandating that 50 percent of all Medicaid recipients in the state be in coordinated care by January 2015. The law provides authority for the state's Department of Healthcare and Family Services (DHFS) to design approaches to coordinated care that include primary care, behavioral health services, hospital services, rehabilitation, and long-term care services. In June 2011, DHFS released a summary of key policy issues related to care coordination, with a request for stakeholder comments.[42]

Plans for coordinated care in Illinois are likely to include a range of innovative approaches to delivery systems and payments, in addition to traditional fully-capitated managed care arrangements. DHFS has asked for stakeholder input regarding special arrangements to accommodate entities that want to provide coordinated care to particularly expensive or otherwise difficult clients and is considering sponsoring demonstration projects to launch care coordination. In conjunction with the opportunities created by the Illinois Medicaid reform law, the Michael Reese Health Trust has provided a grant to support an intensive planning effort involving HHO and the AIDS Foundation of Chicago. Their work is intended to lay the groundwork for creating an Accountable Care Organization (ACO) for a very vulnerable target population of people who are (or will be) enrolled in Medicaid.

---

[42] See http://hfs.illinois.gov/assets/cc.pdf.

7.3. Challenges, Obstacles, and Limitations of Managed Care

7.3.1. The "Usual" Managed Care Organizations Are Not Geared to Serving Chronically Homeless People

Typical MCOs do not have significant experience or staff expertise in providing care to chronically homeless people, and they may not have established contracts or payment mechanisms that support the intensity, frequency, and types of services involved. For example, some MCOs have established programs that rely on case managers or nurses who provide health education or case management services by telephone, an approach not adapted to working with people with complex health and behavioral health needs.

7.3.2. Services May Be Much More Limited for People Who Are "Dually-Eligible" for Medicare and Medicaid

Homeless or formerly homeless "dual-eligibles" (people who are enrolled in both Medicare and Medicaid) typically begin coverage with Medicaid only. While covered by Medicaid, dually-eligible chronically homeless people and PSH residents in Massachusetts are served through MBHP's behavioral health carve-out. However, once Medicare eligibility begins, people must switch to FFS care. When this happens they lose behavioral health coverage for services such as ACT through MBHP and instead get coverage under Medicare for limited inpatient, outpatient, and injectable drug treatment. They supplement this coverage with what can be covered under Medicaid's FFS care, which is more limited and often requires people to change their primary provider relationship.

Massachusetts recently received an award from a grant program administered by the newly-created federal Coordinated Care Office, to demonstrate integrated care for people who are dually-eligible for Medicare and Medicaid. The Coordinated Care Office was established by the ACA with the goal of improving coordination among federal and state governments and supporting innovations in care delivery and financing for "dual-eligibles." One focus of these efforts is the most chronically ill and costly segments of the populations enrolled in both programs. Massachusetts is including people who are chronically homeless in the demonstration.

7.4. Looking Ahead to 2014: How is Managed Care Likely to Change?

Many states are likely to rely on managed care delivery and payment mechanisms as they expand coverage to people who are newly eligible for Medicaid. Medicaid managed care enrollment will likely keep expanding to include other groups of people with disabilities who are currently enrolled in Medicaid. This will make it increasingly important for PSH service-providers to establish contracts with MCOs so they can continue to get Medicaid reimbursement for the services they provide.

Some provisions of ACA may create opportunities for states to re-examine the separation between managed care arrangements for medical care and behavioral health care services and consider re-aligning delivery systems and payment mechanisms to support more integrated approaches to care.

MCOs are expected to play significant roles in the implementation of ACOs, health homes, and other changes in health care delivery and financing. These and other developments may offer new opportunities for MCOs to understand patterns of health care use and costs associated with chronic homelessness and PSH, and to become partners in financing services in PSH in more communities.

8. HEALTH HOMES

The ACA established a new state Medicaid option to provide "health home" services for enrollees with chronic conditions. A "health home" is intended to provide enhanced integration and coordination of primary, acute, behavioral health (mental health and substance use), and long-term services and supports for people with chronic illness across their lifespan. States may offer health home services to "eligible individuals with chronic conditions" who select a designated health home provider.[43] The health home option become available to states on January 1, 2011, and CMS preliminary guidance was issued in November 2010.[44] The usefulness of this new state option for people with chronic patterns of homelessness and residents of PSH is not yet clear.

8.1. Who is Eligible for Health Home Services?

States have some flexibility in defining the population who will be eligible to receive health home services. The law describes chronic conditions that include a mental health condition, a substance use disorder, asthma, diabetes, heart disease, and obesity, and also gives the Secretary of HHS authority to expand this list of chronic conditions. To qualify to receive health home services, a person must have at least two chronic conditions or one chronic condition and be at risk for another, or one SPMI.

A state may decide to offer this benefit to all people who meet the criteria established in the ACA; alternatively, it may choose to target health home services to people with particular chronic conditions, or a higher number of conditions, or more severe conditions. The law stipulated that states *must* serve dual-eligible beneficiaries (who are covered by both Medicaid and Medicare) if they otherwise qualify for health home services.

The types of chronic conditions described in the law include those that are prevalent among chronically homeless people, as well as many other people who are

[43] "Health homes" established under this state option will be similar to but distinct from "medical homes" that are also being considered or implemented by many health care providers and delivery systems. Among other distinctions, medical homes may be established for a wide range of consumers, with or without chronic health conditions or other special needs, who may be covered by private insurance as well as Medicaid or other forms of health coverage. Because medical homes often serve a more diverse patient population, reimbursement rates may be lower than the payment rate for services provided through a "health home" as defined by the ACA provisions. For example Minnesota's multi-payer health care home/medical home initiative provides some complexity-adjustment in payment rates, including adjustments for people with SMI and/or whose primary language is not English. However, the maximum payment rate for the care coordination these health care homes provide will be approximately $65-$80 per month, which will not cover the level of support and care coordination needed by a chronically ill person with complex health and behavioral health conditions.

[44] State Medicaid Director #10-024, November 16, 2010. This letter indicates that CMS will provide additional guidance to states in the future.

enrolled in Medicaid. It is not clear, however, whether a state can establish target criteria for health home enrollment that might take into consideration additional factors such as chronic homelessness or frequent or avoidable use of hospital inpatient or emergency room care.

8.2. Potential for Using the Health Home Option for Residents of Permanent Supportive Housing

In several states, supportive housing service-providers and other advocates are talking with Medicaid program officials about potential opportunities to provide health home services to target populations that will include PSH residents. Some supportive housing service-providers, especially FQHCs, are assessing their ability to become a health home, and some are working to build the capacity to meet current or anticipated health home provider standards. Other supportive housing service-providers are seeking to develop collaborative partnerships with health care providers who are more likely to become health homes.

Several state officials who participated in site visits for this study expressed some hesitation about their fiscal capacity to pursue the new health home option, even though federal matching funding would cover 90 percent of costs for the first two years of implementation. They have some interest in pursuing the option *if* the state could craft target criteria in a way that would achieve overall savings, by providing health home services to people with complex health problems who are high-users of hospital inpatient care.

In **Illinois**, HHO and a few other provider organizations that now serve chronically homeless people are consulting with state Medicaid officials about the possibility of a pilot "health home" project, with the target population strictly limited to chronically homeless, multiply disabled, frequent users of crisis public services. Careful assessment and targeting would be needed to achieve cost neutrality or potential savings in state costs by the time federal matching contributions are reduced to the standard rate after two years.

The pilot project would use Medicaid managed care financing to deliver comprehensive health and behavioral health services. Services could be coupled with housing supported by HUD housing subsidies provided through a partnership with the Chicago Housing Authority and a grant recently awarded to the AIDS Foundation of Chicago through HUD's SHP for new PSH units for chronically homeless persons.

9. CONCLUSIONS AND IMPLICATIONS

Many people are applying considerable effort to finding ways to use Medicaid more consistently to reimburse the costs of services to address the health and behavioral health problems of formerly homeless PSH tenants in ways that help them stay healthy and housed. One of the questions looming over PSH providers--how can we get our clients enrolled?--will change in 2014, when nearly all of their clients will become Medicaid-eligible. But these providers may still need help bringing Medicaid-reimbursed services to their clients. The biggest remaining questions are: "What can be done to get the most effective mix of services covered through Medicaid?" and "What can be done to simplify the reimbursement process?"

The environmental scan conducted for this project found some promising approaches to using Medicaid to finance effective models of care for chronically homeless people with complex health and behavioral health problems. Among those that seem to help fund services in PSH are approaches that:

- Support partnerships or expansions of organizational capacity and development of clinical practices and tools (such as integrated intake and service records) that integrate care for medical and behavioral health problems and reduce fragmentation.

- Adapt medical/service necessity criteria to recognize complex co-occurring conditions and homelessness in addition to a single diagnosis, instead of requiring that every service be justified in terms of a client's mental illness.

- Establish payment mechanisms that enable interdisciplinary teams to deliver services.

- Adapt "gatekeeping" or Utilization Review functions to accommodate hard-to-engage and highly vulnerable homeless people.

- Invest in building the capacity of non-traditional service-providers who serve very vulnerable homeless adults (including organizations providing services in PSH) to become qualified Medicaid providers, and to establish administrative capacity to bill for services.

Documenting the strategies that are a growing part of current practice can encourage broader use of these practices. These include Medicaid-covered services such as CSTs or the delivery of primary care and behavioral health services provided by FQHCs. In addition, the ACA creates or supports the expansion of many innovations in care delivery and financing. Some of these seem particularly promising for improving care for people who are chronically homeless and providing opportunities or incentives to link health care to permanent housing. These include:

- Health homes.

- Behavioral and Primary Care integration demonstrations.

- 1915(i) HCBS Option.

- Dual-eligible demonstrations.

The outlook is mixed for states to move in the direction of providing Medicaid coverage and reimbursement for more services for chronically homeless people with complex health and behavioral health problems. Even when federal matching rates are high--as they are for the new Health Home Medicaid Option--states are wary of expanding benefits if they cannot limit fiscal risk for costs in future years. Many states now have significant budget shortfalls, often accompanied by hiring freezes, layoffs, and/or unpaid furlough days for state workers, against a backdrop of prolonged budget battles playing out in state capitals. This makes it harder for staff and agency leaders to do the labor-intensive work of engaging with local stakeholders and federal officials to develop new programs or amend state Medicaid Plans in order to help move chronically homeless people into permanent housing and support them while they are there, while avoiding the costs for emergency, inpatient, and long-term care for this population.

CHRONIC HOMELESSNESS PERMANENT SUPPORTIVE HOUSING VOUCHER DEMONGRATION EVALUATION DESIGN OPTIONS

Reports Available

Establishing Eligibility for SSI for Chronically Homeless People

HTML	http://aspe.hhs.gov/daltcp/reports/2012/ChrHomls3.shtml
PDF	http://aspe.hhs.gov/daltcp/reports/2012/ChrHomls3.pdf

Health, Housing, and Service Supports for Three Groups of People Experiencing Chronic Homelessness

HTML	http://aspe.hhs.gov/daltcp/reports/2012/ChrHomls1.shtml
PDF	http://aspe.hhs.gov/daltcp/reports/2012/ChrHomls1.pdf

Medicaid Financing for Services in Supportive Housing for Chronically Homeless People: Current Practices and Opportunities

HTML	http://aspe.hhs.gov/daltcp/reports/2012/ChrHomls2.shtml
PDF	http://aspe.hhs.gov/daltcp/reports/2012/ChrHomls2.pdf

Public Housing Agencies and Permanent Supportive Housing for Chronically Homeless People

HTML	http://aspe.hhs.gov/daltcp/reports/2012/ChrHomls4.shtml
PDF	http://aspe.hhs.gov/daltcp/reports/2012/ChrHomls4.pdf

To obtain a printed copy of this report, send the full report title and your mailing information to:

U.S. Department of Health and Human Services
Office of Disability, Aging and Long-Term Care Policy
Room 424E, H.H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201
FAX: 202-401-7733
Email: webmaster.DALTCP@hhs.gov

RETURN TO:

Office of Disability, Aging and Long-Term Care Policy (DALTCP) Home
[http://aspe.hhs.gov/_/office_specific/daltcp.cfm]

Assistant Secretary for Planning and Evaluation (ASPE) Home
[http://aspe.hhs.gov]

U.S. Department of Health and Human Services Home
[http://www.hhs.gov]