



# ASPE ISSUE BRIEF

HHS OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION  
OFFICE OF DISABILITY, AGING AND LONG-TERM CARE POLICY

## STATE STRATEGIES FOR COORDINATING MEDICAID SERVICES AND HOUSING FOR ADULTS WITH BEHAVIORAL HEALTH CONDITIONS

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### About This Study

Mathematica Policy Research collected the data for this Issue Brief as part of a project for the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. The study examined the mechanisms that states are using to improve care coordination for adult Medicaid beneficiaries with behavioral health conditions. The information in this Brief is based on a review of documents and on telephone and in-person interviews conducted in fall 2014. Information was gathered from state Medicaid and/or behavioral health officials, managed care representatives, behavioral health providers, housing providers, and consumer advocacy organizations.

### Introduction

Medicaid beneficiaries with serious mental illness (SMI) or substance use disorders (SUD) often require a range of services and supports to live independently in the community. Accessing services can be challenging for this population, however, especially for individuals who are homeless or lack stable housing. In many states and communities, housing supports and behavioral health services are delivered through different agencies that do not coordinate with each other or with physical health providers. States are therefore looking for strategies that improve the link between Medicaid services and housing.

This Issue Brief describes the strategies used by four states--Louisiana, Massachusetts, Tennessee, and Illinois--to improve the link between Medicaid and housing services for adult Medicaid beneficiaries with behavioral health conditions. This Brief does not assess the success of these strategies, but instead focuses on the mechanisms the states are using to improve care coordination for individuals with both behavioral health and housing needs. Federal and state policymakers and other stakeholders can use this information in developing their own initiatives.

## Highlights of State Initiatives

### ***Louisiana: Management of Permanent Supportive Housing Program Services is Incorporated into the Managed Behavioral Health Plan***

**Overview.** Louisiana's Permanent Supportive Housing (PSH) program subsidizes about 3,300 private rental units and offers Medicaid-covered behavioral health and long-term care services. PSH participants live independently in units that are scattered across different buildings. The program originated in 2005, when the state received federal funding to rebuild affordable housing after hurricanes; the program continues to operate in the hurricane-prone region of the state.

In October 2013, funding for the behavioral health services provided to individuals in PSH shifted from time-limited community development block grant funding to Medicaid. This shift was driven by the need for a sustainable funding source. The state also shifted management of PSH to its single statewide managed behavioral health organization (MBHO), which manages all specialty behavioral health services. The MBHO became responsible for screening PSH applications for Medicaid eligibility, coordinating applications and housing placements with the state housing agency, and managing tenant-landlord relationships, in part due to the state's desire to have a single entity centralize these processes. PSH participants must now qualify for the federal housing subsidies, Medicaid, and the 1915(i) State Plan Amendment that authorizes intensive behavioral health services; beforehand, Medicaid eligibility was not a requirement for PSH participation. Individuals who do not qualify for 1915(i) services, including those without SMI (such as individuals with SUD only), are no longer eligible for the PSH program. Providers are reimbursed under the same rates they receive for delivering services to any Medicaid beneficiary. The state hopes to expand the PSH program statewide.

**Services.** The behavioral health services available to PSH participants are not unique to the PSH program; participants can access the same services available to anyone in Louisiana who is eligible for Medicaid 1915(i) services. PSH participants are likely to receive intensive Medicaid rehabilitation services, such as assertive community treatment (ACT), intensive case management (ICM), or community psychiatric support and treatment. Although participation in services is voluntary, participants must have a certified service provider who is enrolled in the behavioral health network. Since the funding for services shifted to Medicaid, providers can only bill for time spent face-to-face with clients. Time spent searching for a client in the community, assisting a client by telephone, or contacting another provider without the client present is no longer reimbursable. A trade-off to centralizing service management is that providers are no longer reimbursed for the services that transitioned to the MBHO (such as application assistance and tenant-landlord mediation); consumers must now seek such support from the MBHO rather than from their local behavioral health providers.

## ***Massachusetts: Medicaid Managed Behavioral Health Organization Covers Care Coordination for Chronically Homeless Individuals in Permanent Supportive Housing***

**Overview.** Since 2006, the Community Support Program for Ending Chronic Homelessness (CSPECH) has provided community-based care coordination for chronically homeless adults in supportive housing. CSPECH is a Medicaid-reimbursed service offered by the state's MBHO (Massachusetts Behavioral Health Partnership [MBHP]) and available through eight providers across the state. MBHP covers CSPECH through its capitated Medicaid payment and reimburses providers using a flat per-client case rate.

Recognizing the critical role housing plays in stabilizing the health of chronically homeless individuals, CSPECH seeks to achieve Medicaid cost savings by serving this high-cost population in PSH rather than on the street or in shelters. Participants live in various types of subsidized housing, including scattered and single-site buildings. To be eligible for CSPECH, individuals must meet the U.S. Department of Housing and Urban Development's (HUD's) definition of chronic homelessness and elect to enroll in the MBHP plan (MBHP members receive physical health services through a traditional fee-for-service arrangement). The state Medicaid agency hopes that the other managed care organizations (MCOs) in the state, which cover physical health and behavioral health services, will cover CSPECH in the future. The availability of CSPECH services is constrained by the limited supply of affordable housing and housing vouchers; receipt of services is guaranteed only after a housing unit and subsidy are available.

**Services.** CSPECH providers hire community support workers (CSWs) to deliver coordination support services. The CSW services are reimbursable beginning 90 days before an individual is housed, an arrangement that makes it easier for CSWs to help homeless individuals secure housing. Services continue for as long as the individual lives in the subsidized unit. CSWs work with a caseload of up to 12 clients, as required by the MBHO. Coordination services include helping clients obtain a primary care provider, driving or accompanying clients to appointments, following up on referrals and prescriptions, assisting with community reintegration, strengthening independent living skills, and helping clients enroll in social service programs (such as Supplementary Security Income and food stamps).

## ***Tennessee: Supervised Group Homes are Integrated into the Managed Care Arrangement***

**Overview.** TennCare is a statewide, mandatory managed care program serving Tennessee's entire Medicaid population. Behavioral health services have been carved in since 2007. The state's Medicaid program includes a supported housing benefit, which covers support services provided in supervised group housing facilities that are staffed by mental health providers around the clock and that have fewer than 16 beds. The benefit is intended to be relatively temporary and to serve as a bridge for individuals coming from institutions and other restrictive settings to more independent living in the community. To be eligible for group home placement, a person must meet medical necessity and level of care criteria and require services and supports in a highly

structured setting. The supported housing benefit thus offers limited coverage to a narrow population. State respondents did not mention plans to alter the benefit in the future; one MCO interviewed is exploring how to use its capitated rate to provide supplemental housing support services to beneficiaries who are not eligible for the supported housing benefit.

**Services.** While in a group home, individuals can receive various services covered under the supported housing benefit. For example, through one of the managed care plans, group home residents work with mental health professionals to create individualized care and discharge plans that address mental health, physical health, and/or substance abuse conditions. The discharge plans include a housing transition plan that specifies possible housing options for the client, along with next steps for choosing one of those options. Group home providers are expected to coordinate with clients' other behavioral or physical health care providers to help ensure that residents are following through with their treatment plan and receiving continued care. Residents also receive mental health counseling while in the group home, and can receive other forms of psychiatric rehabilitation, such as supported employment, which is billed as a separate psychiatric rehabilitation benefit.

### ***Illinois: Medicaid-Funded Care Coordination Entities Foster Partnerships between Local Health and Housing Providers***

**Overview.** In September 2013, Illinois launched the first of six regional Care Coordination Entities (CCEs). CCEs are new partnerships of community-based providers that include behavioral health, physical health, housing, and social service agencies. CCEs primarily coordinate behavioral and physical health care, with a secondary focus on coordinating housing and other psychosocial needs. The agencies comprising a CCE are bound by formal agreement and represented by a new care coordination team that operates under the CCE. For each CCE, the state Medicaid agency auto-enrolled between 1,000 and 1,500 Medicaid beneficiaries with complex health needs, particularly those with behavioral health conditions. Many of these individuals were homeless.

The state Medicaid agency, which oversees the CCEs, uses state funds to pay the CCEs a per-member per-month (PMPM) coordination fee, which enables them to hire the care coordination team. Payment for all other Medicaid services is covered separately through a fee-for-service arrangement with the state. Although the PMPM fee primarily covers care coordination, CCEs can use it to cover other costs that are not Medicaid-reimbursable; they are unlikely to do so before they scale up enrollment, however. For housing providers whose services are neither covered by Medicaid nor the PMPM, CCE membership is an investment and part of a long-term strategy to participate in an evolving service system. The Medicaid agency does not intend to expand CCE enrollment but instead hopes that CCEs will market their care coordination model and services to the MCOs.

**Services.** The CCE initiative has not created new housing options or supports; rather, CCEs facilitate coordination with existing housing supports. All beneficiaries are assigned to a care coordination team, consisting of mental health and community health

professionals, many of whom have housing experience. The team's main focus is on coordinating physical and behavioral health services. Coordinators also assess and attempt to address clients' housing and other psychosocial needs, although their resources for doing so are relatively limited. The CCE care coordinators mainly rely on their housing provider members to help connect clients to existing housing services and subsidies. By bringing local providers of different service systems together, CCEs enable members to share knowledge, information, and resources specific to their service area.

## **Overarching Strategies for Linking Medicaid and Housing Services**

Increasingly, states are recognizing the value of improved integration and coordination of housing and Medicaid services for individuals with behavioral health conditions. This Brief highlights examples of integration and coordination strategies from four states (see Table 1 for a summary of state strategies). There are some common elements across the states.

### ***States are Encouraging Managed Care Plans to Focus on the Coordination of Behavioral Health and Housing Services***

Three of the states included in this study have required or allowed their Medicaid-managed care plans to develop and reimburse care coordination strategies specifically focused on beneficiaries with housing needs. Managed care entities have a financial incentive to decrease hospitalizations, emergency department visits, and other costly service utilization among people with unstable housing situations. Further, managed care entities are, in theory, well-positioned to use their data to monitor service use and outcomes; these data can inform individual-level treatment planning and care management while also providing information that can improve service delivery systems. Linking data on behavioral health and housing participation (as the MBHO in Louisiana has done) offers additional opportunities for monitoring care.

Three of the states are using waivers and/or State Plan Amendments to authorize enrollment of Medicaid beneficiaries in managed care and to provide services for individuals in supportive housing. Managed care plans in Massachusetts and Tennessee operate under an 1115 demonstration waiver. Louisiana, in contrast, uses a 1915(b) waiver for prepaid inpatient health plans to authorize the MBHO for adult behavioral health services; the state uses a 1915(i) State Plan Amendment to enable Medicaid coverage for intensive behavioral health services. Although the CCE initiative in Illinois is not currently under a managed care arrangement, the state Medicaid agency intends for the CCEs to be appealing as a purchased service of the MCOs, if the CCEs can demonstrate that care coordination services are cost-effective.

## **States and Managed Care Entities have Created Reimbursement Mechanisms that Facilitate Care Coordination**

*"Getting someone into permanent supportive housing and keeping them there is largely dependent on the relationship they have with the supports that keep them [housed]."*

*~ Behavioral health provider in Louisiana*

Ensuring that individuals who are homeless or unstably housed receive services to maintain their housing requires intensive human interactions, including interactions that take place in person and in the community. Representatives from the four states in this study emphasized that these high-need individuals require a commitment of time and resources from dedicated staff. Massachusetts and Illinois have created mechanisms that reimburse providers for in-person care coordination. As part of their per-client case rate, CSPECH staff in Massachusetts support the needs of individuals who are housed. In contrast, CCE care coordination teams in Illinois provide targeted care coordination to clients through a PMPM fee. Louisiana's PSH participants must have a supportive service provider, who may deliver case management services and work with other state and local PSH stakeholders to coordinate care. Tennessee's Medicaid benefit supports services in small group homes that are staffed 24/7 by mental health professionals. Staff work with group home residents to develop treatment and housing transition plans and to coordinate care with other providers.

*"[CSPECH] is not ultimately a housing program, but a service delivery program. Providing housing is the bridge to providing the services for this population."*

*~ Housing advocate in Massachusetts*

Representatives from consumer groups, behavioral health providers, and housing providers across states reported that reimbursement for care coordination and care management was essential to connect individuals with severe behavioral health needs in supportive housing to services and to ensure that they continue in treatment. As a behavioral health provider in Louisiana noted, offering services to individuals in stable housing helps them to engage in care. Providers also reported that care coordination supports help people remain housed in the community. Additionally, managers of homeless shelters in Massachusetts reported that the availability of CSPECH has helped property managers feel more comfortable renting to tenants with serious behavioral health challenges, creating new housing opportunities for their clients.

## **State Initiatives are Fostering Local Partnerships between Providers**

*"It is essential for the success of any supportive housing program that there be a lot of communication between the elements of the program. Programs that don't have a lot of communication just aren't as good. The supportive services tend to break down, and the housing ends."*

*~ Housing provider in Louisiana*

Several providers, health plans, and state officials reported that local partnerships were key to the success of their efforts. Each state implemented financing mechanisms at the state level to facilitate and encourage collaborations between local providers. Such collaborations are particularly helpful for identifying limited housing resources, given that Medicaid only covers physical and behavioral health services. Local behavioral health providers in three states, along with the MBHO in one of the states, are building relationships with private housing providers; educating them about the supports their tenants will receive; and making themselves available to address the physical health, mental health, and psychosocial barriers that often put people at risk of losing their housing. Behavioral health and housing providers in Louisiana's multi-agency PSH program noted that securing and maintaining tenancy requires significant collaboration and communication between local behavioral health and housing providers and the MBHO. Providers in Illinois are educating one another about the availability of housing and other supports in their communities. As one CCE provider noted, "We were all serving the same clients, so working together just makes sense."

*"When thinking about the future of health care, housing must be part of the equation and [the CCE initiative] is an opportunity to have housing recognized, even if related [housing] services are not yet being covered."*

*~ CCE housing provider in Illinois*

The partnership structures in these states differ based on local contexts and funding mechanisms. In some of the states, the reimbursement mechanisms grant providers flexibility to develop collaborations that take advantage of existing local housing infrastructure. In Illinois, for example, housing providers with access to housing subsidies and other local housing resources are members of the CCEs. In Massachusetts, the behavioral health entity has structured the CSPECH benefit flexibly enough to enable different partnership structures: three of the eight CSPECH providers are partnerships between a community mental health center (CMHC) and one or more housing providers, two are led by a Federally Qualified Health Center (FQHC) that has partnered with one or more local housing providers, and three are led by a single organization that provides both behavioral health services and housing. Similarly, behavioral health providers in Tennessee either own and operate a group home themselves, or contract with local housing providers who own and operate the housing and/or support services. Louisiana's PSH program, which was built with new housing subsidies, created new formal partnerships between state housing and behavioral health agencies, the MBHO, local behavioral health providers, subsidy administrators, and landlords or property managers.

## Conclusion

As these four states demonstrate, Medicaid offers states flexibility to invest in initiatives that have the potential to improve the coordination of behavioral health and housing services. Building on their existing infrastructure, the states developed these initiatives under different financing authorities and using different reimbursement mechanisms and partnership structures. All of these states rely on creative financing arrangements and on-the-ground support for beneficiaries. The strategies described here could be useful for other states and communities seeking to strengthen the link between Medicaid services and housing.

This Issue Brief, authored by Rebecca Kleinman, Matthew Kehn, Allison Wishon Siegwarth, and Jonathan Brown, describes the strategies used by four states--Illinois, Louisiana, Massachusetts, and Tennessee--to improve the link between Medicaid and housing services for adult Medicaid beneficiaries with behavioral health conditions.

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**TABLE 1. Summary of State Initiatives to Improve Link Between Housing and Behavioral Health Services**

	Louisiana	Massachusetts	Tennessee	Illinois
Overview	Medicaid MBHO manages PSH program services and links beneficiaries to other Medicaid services.	Medicaid MBHO offers CSPECH.	Medicaid MCOs cover supported housing benefit that provides services in supervised group homes.	State Medicaid agency funds 6 CCEs--new partnerships of local behavioral health, physical health, housing, and social service agencies.
Behavioral health services offered	Any behavioral health service under Medicaid State Plan; clients can receive intensive supports, such as ACT or ICM.	CSPECH providers hire CSWs to coordinate care.	Small group homes offer 24/7 access to mental health professionals, who coordinate with other care providers and create treatment and discharge plans.	Clients are assigned to a CCE care coordination team; coordinators are networked to housing providers in the CCE and many have housing experience.
Reimbursement mechanism	State capitated payments to MBHO; MBHO pays providers for services.	State capitated payments to MBHO; MBHO pays providers flat per-client case rate.	State capitated payments to MCOs; MCOs pay providers for services.	PMPM coordination fee from Medicaid state agency.
Medicaid financing authority	Managed care via 1915(b) waiver; intensive services via 1915(i) State Plan Amendment.	Managed care via 1115 demonstration waiver.	Managed care via 1115 demonstration waiver.	Not required.
Target population	Medicaid adults who need housing and support services, have SMI, and are eligible for 1915(i) services.	Medicaid adults enrolled in MBHP who meet HUD definition of chronic homelessness and are placed in housing.	Medicaid adults who need temporary, highly structured support, primarily those transitioning from institutions to independent living.	Medicaid adults with behavioral health conditions, particularly those who are homeless.
Key partners	State housing and health agencies, MBHO, behavioral health providers, housing providers, landlords/property managers.	CMHC or FQHC contracts with housing providers, or 1 organization provides behavioral health and housing services.	Behavioral health providers own and operate a group home themselves or contract with local housing providers.	CCEs include behavioral health, physical health, housing, and social service agencies.
Geographic scope	Southwest and Southeast regions.	Statewide; 8 CSPECH providers.	Statewide	6 regional CCEs.

**TABLE 1 (continued)**

	<b>Louisiana</b>	<b>Massachusetts</b>	<b>Tennessee</b>	<b>Illinois</b>
Housing setting	Independent scattered-site units.	Independent housing, including scattered and single-site units.	Supervised group homes with less than 16 beds.	Locally available housing; some clients are homeless.
Resources to subsidize housing	HUD funding.	Predominantly HUD funds, some state funds and other resources.	Mix of funds from state, HUD, private insurers, and others.	Predominantly HUD funds, some state funds and other resources.
Constraints	Medicaid funding narrowed eligibility; centralizing services reduced local support; providers are no longer reimbursed for telephone contacts.	Availability is constrained by the limited supply of subsidized housing; participants must enroll in MBHP.	Coverage is temporary and limited to supervised group homes and a narrow population.	Coordination with housing is a secondary goal; subsidized housing is limited; participants must enroll in a CCE.

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