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Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy



MEDICAID AND PERMANENT SUPPORTIVE HOUSING FOR CHRONICALLY HOMELESS INDIVIDUALS:

LITERATURE SYNTHESIS AND ENVIRONMENTAL SCAN

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Office of the Assistant Secretary for Planning and Evaluation

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MEDICAID AND PERMANENT SUPPORTIVE HOUSING FOR CHRONICALLY HOMELESS INDIVIDUALS: Literature Synthesis and Environmental Scan

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INTRODUCTION

This document is the first product of our Environmental Scan, reflecting existing published and unpublished literature on permanent supportive housing (PSH) for people who are chronically homeless. It has a particular focus on the role that Medicaid currently plays in covering the costs of the supportive services that help people keep their housing and improve their health and quality of life. In addition to written material, this document incorporates the knowledge of housing and service configurations and ways that providers have been able to cover the cost of supportive services, garnered over our many years in the field. It also reflects some information we received through telephone conversations preliminary to making recommendations for communities to visit. This version of the literature synthesis will be augmented with the results of site visits and in-depth telephone interviews to form the final Task 4 product.

We know from much research that “supportive housing works” (Caton, Wilkins, and Anderson, 2007). But we also know that it is always a challenge to assemble the resources to sustain supportive housing tenants in their housing, due to their long histories of homelessness and complex health and behavioral health conditions.

Current strategies in the United States for financing the supportive services component of PSH are far from optimal. Ideally, these supportive services would include housing stabilization early in a person’s PSH tenancy, integrated provision of primary care, mental health and substance use conditions care, medication optimization and management, dental care, and overall continuing care management. They might also include supports for entering and sustaining employment, reconnecting with family, and participating in the life of the community. Given all the service elements that need to be coordinated and integrated to reach this ideal, the best programs (those with the best housing and other outcomes for tenants) invest a good deal of time in case conferencing, meetings between landlord/property managers and service team members, and other practices designed to keep tenants stably-housed and adequately supported.

Best practices in integrated care have their challenges, but increasing numbers of PSH housing/service teams are meeting them. One of the biggest challenges is finding the resources to support all the activities that lead to stably-housed tenants. This challenge is amplified by the restrictive eligibility criteria that govern Medicaid, which might otherwise be able to cover many of the costs of PSH services. In addition, there are even more restrictive eligibility criteria for some types of Medicaid-covered services, based on “medical necessity” or “service necessity” in relation to severity of diagnosis or impaired functioning. Medicaid eligibility is slated to expand greatly in 2014 under the Affordable Care Act, but even then there will be challenges similar to many that are observable today that will *need* to be met and resolved before Medicaid can serve as a more reliable funding resource for PSH tenants. Thus it is important for us to understand today’s challenges in using Medicaid and the ways they are being addressed, so future uses of Medicaid under the Affordable Care Act may be designed

to facilitate rather than stymie the use of Medicaid to help chronically homeless and disabled persons leave homelessness and sustain housing.

Funding for homeless, behavioral health and other health care services currently being used for supportive housing tenants is often fragmented across many public sector programs and agencies and the non-profit service providers they support. Funds flow from different state and county agencies, through different entitlement and benefit programs governed by their own regulations and mandates. This complicated picture includes state and county appropriations (homeless, mental health, substance abuse, criminal justice, public health) and federal programs and funded entities (Department of Housing and Urban Development (HUD), Medicaid, Medicare, Substance Abuse and Mental Health Services Administration (SAMHSA) Block Grants and program grants, and Health Resources and Services Administration (HRSA) Primary Care Block Grants, Federally Qualified Health Centers (FQHCs), Community Health Centers (CHCs) HealthCare for the Homeless (HCH) Programs, other sources of funding for homeless programs, and Ryan White Grants). From the prospective enrollee's point of view, program rules often conflict or leave large components of service need uncovered.

Finding the resources to support specific service elements such as primary care, mental health treatment, or dental services is difficult enough. The hardest element of care to fund, though, is "the glue" that holds them all together in the service of providing PSH tenants with holistic care. "The glue" includes:

- Early activities to induce prospective tenants to accept housing and stabilize new tenants in housing and to engage them in the services and supports that will address their health, mental health, and addictions problems.
- Care coordination, including planning, involving staff able to offer all the different services needed, assuring regular consideration by team members of the tenant's well-being and challenges to it, and, most of all, establishing a relationship of trust, openness, and support with each tenant.
- Team-building with support staff from multiple disciplines, training, and agency affiliation, independent of handling individual cases, including cross-training. Making this happen often requires external influence to bring the relevant parties together and keep them together.

The Office of the Assistant Secretary for Planning and Evaluation's (ASPE's) primary interest in this project is in learning as much as possible that will help it shape the most useful possible demonstration and, ultimately, structure access to Medicaid and appropriate care once Affordable Care Act provisions render most people who are homeless eligible for Medicaid in 2014. ASPE is already convinced that PSH works, and has recognized that the Department of Health and Human Services' (HHS') primary resource to support PSH, Medicaid, is less widely used to pay for needed services than might be the case. A good bit of this underuse occurs because a relatively small percentage of people who are chronically homeless are eligible for Medicaid and an

even smaller percentage are actually recipients, either before or during PSH residence. Many people who are chronically homeless will qualify in 2014 under the Affordable Care Act, or earlier for early implementer states, do not qualify now, but it is also true that many who could qualify now are not beneficiaries because the hurdles in the way of establishing eligibility are many and high.

Other factors contributing to underuse include insufficient provider capacity, administrative/ bureaucratic barriers to expanding the provider base, and inadequate opportunities at the state and local levels to match Medicaid expenditures as required by law. State and local budget limitations are particularly important, because most of the services that could be financed by Medicaid in PSH are covered as optional Medicaid benefits. States have considerable flexibility in deciding whether to cover these benefits and how to tailor provider qualifications and reimbursement rates as well as medical necessity criteria governing their use. Many states facing budget shortfalls have reduced coverage for optional benefits under Medicaid or are considering significant reductions that could limit opportunities to use these benefits to reimburse new service providers or to expand the availability of Medicaid-covered services for PSH tenants.

Despite these challenges, some communities, and some provider agencies, have developed ways to help people who are chronically homeless establish eligibility, just as they have developed ways to use Medicaid to cover a variety of treatments and services, delivered by several different types of agency. To support ASPE objectives in planning for the evaluation of the PSH Voucher Demonstration, this document summarizes existing published literature, unpublished program documents, and information obtained from telephone conversations with key informants, to:

- Provide evidence of how much benefit derives from PSH, in terms of avoiding crisis health care costs and enhancing the health and well-being of PSH tenants. The authors address this in Section 1 of this synthesis.
- Describe the basics of housing options for people who are chronically homeless and how supportive services currently complement them and identify the ways that Medicaid is currently being used as one source of funding for supportive services in PSH. We do this in Section 2 of this synthesis.
- Identify the most effective practices currently in use to increase Medicaid enrollment among people who are chronically homeless and formerly homeless, through both categorical eligibility (via Supplemental Security Income (SSI)) and other mechanisms, and to get current Medicaid beneficiaries among those who are chronically homeless into PSH. We do this in Section 3 of this synthesis.

In Section 4, we preview how the implementation of health care reform could affect Medicaid funding of services in PSH. Finally, in Section 5 we summarize what we have learned in this first stage of the environmental scan. The authors discuss the implications of findings, including how the results of a demonstration of PSH could contribute to creating the most effective possible Medicaid Program in 2014 under the Affordable Care Act.

1. WHY IT IS IMPORTANT TO LINK HOUSING ASSISTANCE WITH MEDICAID-FUNDED HEALTH SERVICES

In this section we summarize findings related to two reasons why investing in services to formerly homeless persons in PSH is worth doing. The first reason--the one best known and most frequently cited--is that ending chronic homelessness through PSH tenancy helps avoid public costs for crisis health services as well as public outlays in other areas such as corrections. The second reason is that housing individuals who are chronically homeless improves their health and other aspects of their lives.

1.1. Cost Avoidance

Policy makers and the public have long been interested in the cost of homelessness, so the first cost-related studies sought to document these costs (research summarized in Culhane et al., 2007). More recently, HUD sponsored an extensive study of the cost of first-time homelessness for families and single adults that was able to determine pathways followed by people entering homeless systems in seven communities, as well as the costs they incurred in the homeless system and a select few mainstream public systems (Spellman et al., 2010).

Interesting as these results have been, however, the findings that have captured public attention and changed policy look further than the simple cost of homelessness. They focus on the change (reduction) in the cost of public crisis services that occurs once persons with long histories of homelessness and one or more disabilities move into PSH.

The findings of numerous studies amply attest to reductions in crisis public service use and cost when individuals who are chronically homeless move into PSH. The first of these studies to receive widespread public notice (Culhane, Metraux, and Hadley, 2002) examined the effects of the supportive housing offered to persons who are homeless with severe and persistent mental illness (SPMI) through the New York/New York (NY/NY) Initiative beginning in 1991. It found that the cost of PSH housing and services roughly offset the public costs to hospitals, mental health services, corrections, and the Department of Veterans Affairs (VA) that PSH tenants would have incurred had they not been housed.

Rosenheck, Kaspro, Frisman, and Lui-Mares (2003) examined the outcomes for veterans with mental illness enrolled in the first supportive housing program for veterans (known as HUD-VA supported housing (VASH)) and a control group randomly assigned to "usual treatment." These researchers also found cost offsets. Although some proportion of public costs were not offset (about 17 percent), the authors concluded that the improved outcomes for the veterans were worth the difference. Another early study in Connecticut (Andersen, 2000) that looked only at Medicaid costs also found

significant reductions following PSH placement of homeless single adults (not all of whom were chronically homeless), as well as shifts to more appropriate care through outpatient clinics.

These early studies, and especially the NY/NY Initiative analysis, were key pieces of evidence needed for advocates to propose and federal decision makers to adopt a change in national policy--toward a commitment to ending chronic homelessness. The other two pieces of evidence were: (1) results showing that agencies providing PSH could move long-term persons who are homeless and have significant levels of disability off the streets and keep them housed; and (2) evidence from national studies that the number of disabled chronically homeless individuals was small enough to be manageable, and chronic homelessness solvable.¹

1.1.1. *The Latest Evidence*

In recent years, quite a number of communities have mounted cost avoidance studies of their own, often motivated by the desire to show local decision makers that the findings of nationally recognized studies also pertained to their own locations. These studies all show one level or another of cost offsets. Some show that the cost of providing PSH is actually lower than the combined costs incurred by public agencies for the same people when they were homeless, while others show significant cost offsets but not actual savings compared to the cost of supporting people in PSH plus the cost of remaining public service use. Some studies have focused on specific buildings or projects; these include:

- A study of 1811 Eastlake, run by Seattle's Downtown Emergency Services Center (Larimer et al., 2009), that targeted the most frequent users of alcohol-related hospital emergency room care, the sobering center, and the county jail, and showed substantial cost savings.
- A study of "Begin at Home," run by Seattle's Plymouth Housing Group (Streblick, 2007) that also showed significant cost offsets for the frequent users of health and substance abuse services who were able to move into PSH offered by the program.
- A study of Central City Concern's (CCC's) Community Empowerment Program, in Portland, Oregon (Moore, 2006), that also showed cost savings.
- Two studies in Maine, one in the greater Portland area (Mondello et al., 2007) and one, the first in the country to focus on an entirely rural population (Mondello et al., 2009), that showed cost savings while developing study techniques to cover a very broad array of services offered by 102 organizations and the ability to conduct a cost analysis statewide in a very rural state.

¹ Analyses done by M.R. Burt for the Office of Special Needs Assistance Programs/HUD, based on data from the 1996 National Survey of Homeless Assistance Providers and Clients.

- A study of frequent users of health services in six California counties (Linkins, Brya, and Chandler, 2008) that showed cost offsets from providing frequent users with care coordination, and also determined that these offsets were greatest when homeless frequent users obtained housing during the follow-up period.
- A study of the Minnesota Supportive Housing and Managed Care Pilot Project (National Center on Family Homelessness, 2009), run by Hearth Connection in the Ramsey (St. Paul) and Blue Earth (Mankato) Counties in Minnesota, this is the only study to include families as well as single adults in a cost offset analysis for PSH tenants. The cost aspect of the study retrieved administrative data from many public systems; it showed relatively small cost offsets, even though its participants did have long histories of homelessness and extensive disabilities and health problems. It did, however, document shifts in public service use from inpatient and corrections settings to more appropriate outpatient care.
- Cost avoidance information was collected for one year before and one year after the first 49 individuals were housed in Skid Row Los Angeles' Project 50. Participants averaged 9.8 years homeless; 55 percent were tri-morbid (mental health, substance use, and chronic illness conditions). Results showed that more money was spent on hospital and jail visits during the year prior to housing than the net operating cost of Project 50. Inpatient days were reduced by about 75 percent, emergency department visits by about 70 percent, and days in jail by about 83 percent (Los Angeles County Department of Mental Health (LAC DMH) PowerPoint).
- A very extensive and complex study in Los Angeles (Flaming et al., 2009) examined service use across nine public agencies for over 10,000 recipients of General Relief, many of them homeless. The study found cost offsets for housing placement while considering several levels of service need and use of services. It showed that public costs go down when individuals are no longer homeless--(1) 79 percent for chronically homeless, disabled individuals in supportive housing, even though the supportive services they receive are the most intensive and expensive; (2) 50 percent for the entire population of homeless General Relief recipients when individuals move temporarily or permanently out of homelessness; and (3) 19 percent for individuals with serious problems (jail histories and substance abuse issues) who received only minimal assistance in the form of temporary housing. This study showed the benefits of the more costly services accompanying PSH for the sickest and most disabled persons--the first time that the effect of services *per se*, distinct from just the housing, can be clearly detected in both health outcomes and cost offsets.
- An assessment conducted by the Northeast Program Evaluation Center (Rosenheck and Mares, 2009) of the cost impact of providing PSH to 734 chronically homeless individuals in the 11 projects funded during the first wave of

the federal Collaborative Initiative to Help End Chronic Homelessness (CHI), that found a 79 percent reduction in mental health service costs and a 73 percent reduction in total health care costs over the four years during which follow-up was conducted after enrollment in one of the projects.

- Other studies with similar results have been done for statewide pilot projects in Massachusetts (Massachusetts Housing and Shelter Alliance, 2009) and Illinois (Heartland Alliance Mid-America Institute on Poverty, 2009), for a state-sponsored pilot project in Rhode Island (Hirsch et al., 2008), and for participants in Denver's Housing First Collaborative (Perlman and Parvensky, 2006), one of the 11 projects funded during the first wave of CHI.
- Another study (after Flaming et al., 2009 for Los Angeles) to assess use of services and associated costs for a whole city's chronically homeless single adult population (n=2,703) was recently completed in Philadelphia (Poulin et al., 2010). Data on service use and costs were obtained for psychiatric care, substance abuse treatment, and incarceration, but not physical health care. Results showed that for behavioral health services and jail, the highest-cost 20 percent of the study population absorbed 60 percent of the total service cost, with psychiatric care and jail stays accounting for most of this. The lowest-cost quintile absorbed only 2 percent of total behavioral health and jail costs. Among those in the highest-cost quintile, 81 percent had a diagnosis of SPMI, while in the lowest-cost quintile 83 percent had a history of substance abuse treatment but no SPMI diagnosis. Clearly, housing highest-cost quintile members in PSH will produce substantial cost offsets. It might appear that the same would not be true for other chronically homeless adults, and especially not for those in the lowest-cost quintile. However, the study's omission of physical health care, including emergency department use and hospitalizations, ambulance services, and similar care for physical health problems probably resulted in a significant understatement of public costs incurred by this "lowest quintile" population. Therefore, it is impossible to draw the conclusion that providing people in this quintile with PSH would not be cost-effective. Results from Larimer et al. (2009, cited above) for residents of 1811 Eastlake would lead to the opposite conclusion.
- Studies of the effects of housing on use of public services by people living with chronic medical conditions including HIV/AIDS in Chicago (Sadowski et al., 2009) and San Francisco (Schwarcz et al., 2009) showed substantially reduced use of emergency departments and hospitalizations, and their accompanying costs, for housed study participants and lower costs for those randomly assigned to housing compared to those who remained without housing.
- Researchers are using these findings to evaluate the "cost per quality-adjusted life year (QALY) saved" of housing when considered as a dimension of health care for people living with HIV/AIDS (PLWHA)--a function of the cost of services provided, transmissions averted, medical costs avoided, and life years saved.

Preliminary calculations indicate that housing is a cost-effective health care intervention for PLWHA, with a cost per QALY in the same range as highly active antiretroviral therapy and other widely accepted health care interventions such as renal dialysis (Holtgrave, 2009).

1.1.2. Caveats

Culhane et al. (2007) offer a number of caveats to the general impression that providing people who are homeless with PSH saves the public money, to which we add others. Recent evidence has in no way changed the importance of those caveats, which policy makers would do well to bear in mind.

- **How frequently do prospective tenants use public services?** The more prospective tenants use public services, the more they cost the public, and the more cost offsets will be realized by moving them to PSH. Providing PSH to people who have been homeless a long time and have multiple and complex health and behavioral health conditions and/or frequent stays in correctional institutions are the most likely to reduce such use significantly. They are thus most likely to contribute significant reductions in public cost once housed, up to and including actual savings (reductions in public costs in excess of the cost of housing and supportive services). The more the people moving into PSH resemble the general homeless population (even the population that has been homeless for a year or two but not for decades), the less cost offset one is likely to see. *Where We Sleep* (Flaming et al., 2009), analyzing data on over 10,000 single adult General Relief recipients in Los Angeles, finds that characteristics of the costliest individuals include those who are older, disconnected from employment for long periods, disabled, mentally ill, and substance abusers.
- **Which cost factors are included in the offset analysis?** In drawing conclusions from existing studies about which subsets of the homeless population are likely to experience significant reductions in use of crisis public services once housed in PSH, it is vital to consider which costs were included in the analysis. As noted above, Poulin and colleagues (2010) draw a conclusion about the likely lack of savings from housing people with addictions but no mental illness that contradicts the conclusions of Larimer and colleagues (2009). The contradiction most likely owes a good deal to the differences in which costs were examined in the two studies. Evidence from a new study by Raven and colleagues (2010) strongly suggests that chronic substance users make substantial inappropriate use of crisis medical resources that Poulin et al. did not capture because their study did not include Medicaid physical health claims data. Summarizing qualitative findings for 50 Medicaid-insured inpatients with frequent hospitalizations, Raven and colleagues report:

Substance use (SU) disorders adversely impact health status and contribute to inappropriate health services use. ... Patient drug/alcohol history, experiences with medical, psychiatric and addiction treatment, and social factors contributing to readmission were evaluated. Three

themes related to SU and frequent hospitalizations emerged: (a) barriers during hospitalization to planning long-term treatment and follow-up, (b) use of the hospital as a temporary solution to housing/family problems, and (c) unsuccessful SU aftercare following discharge. These data indicate that homelessness, brief lengths of stay complicating discharge planning, patient ambivalence regarding long-term treatment, and inadequate detox-to-rehab transfer resources compromise substance-using patients' likelihood of avoiding repeat hospitalization. Intervention targets included **supportive housing** (*emphasis added*), detox-to-rehab transportation, and post discharge patient support (*Abstract*, p. 22).

- **How extensive, and expensive, are the services used by prospective PSH tenants?** Communities that offer many public services will realize more extensive cost offsets and/or savings than communities that offer few or no relevant public services to homeless individuals. If mental health care is missing or severely restricted, if shelters are not available or if their cost is borne entirely by private entities such as religious congregations, and so on, then there are few or no public costs to offset. The cost of PSH will not be balanced by reductions in the cost of public services to nearly the extent that it is in communities with more generous benefits for homeless individuals.
- **Who pays and who saves?** Few of the cost offset analyses to date are attentive to the level of government--federal, state, or local--that actually pays the bills (one exception, National Center on Family Homelessness, 2009). Burt (2008) does so for the cost of PSH capital, operating, and service expenses, looking at federal, state, local (city and county), and private funding, but does not examine public costs averted for crisis services. Yet “who pays and who saves” makes a big difference to decision makers at each level of government. For example, decisions to expand the number of Medicaid recipients, or the number of Medicaid providers, or expand Medicaid services, will potentially run into opposition from the state or local entities that must provide the financial match. Further, savings may accrue in the jail budget (usually state or local money) but not in Medicaid, or vice versa.
- **Will overstressed public systems really see any savings?** While there is no question that housing once-homeless frequent users of public services frees the public resources that they personally consumed disproportionately, that does not necessarily mean that hospital or jail budgets will go down. Most public systems such as hospitals and jails cannot meet the need for care that currently exists. It may be true that excessive and sometimes avoidable use by a few frequent users will be reduced, but there will often be other patients or inmates who will fill the beds. The systems will be used more efficiently, but in all likelihood the costs to those systems will remain the same, with the systems being able to serve more patients.

1.1.3. Implications for HHS/ASPE

- Targeting the frequent users of health services will produce the greatest reduction in inappropriate health service use and cost; the effects may be smaller for people with less complex needs who make fewer demands on public crisis services.
- The greater investment in health services required by those individuals who are sickest, most disabled and chronically homeless pays off in even greater cost offsets than can be gained by providing services and supports for people who are homeless with less complex health and behavioral health problems.
- The more complex a PSH tenant's health and behavioral health problems, the more essential it is that their primary care, mental health care, substance abuse treatment, pharmacological needs, and other treatment be integrated--making it essential that providers have a way to cover the costs of care coordination and integration.

1.2. Impact on Tenant Health and Well-Being

Interest has been high in learning whether tenants experience improvements in mental health symptoms and functioning, whether they reduce their use of addictive substances, and whether they report improved quality of life and general satisfaction. Various studies have looked at what happens to tenant health and well-being once they move into PSH. We report and summarize the results on these issues that are reported in some of the studies already reviewed for their cost information, as well as studies being done in a relatively new area of research--the role of housing in improving outcomes for persons living with HIV/AIDS. For each outcome, we present studies that found an impact, describing the study's location, and sample size and methodology where they are reported. Both sample size and methodology vary greatly, and it is not always possible to tell from available reports or publications whether an intervention had no effect on a particular outcome, the outcome was measured but not reported, or the outcome was not measured. We report the information available, citing "no impact" results only if they are reported as such for a particular outcome.

Please note also that we do not include a section on housing stability because it is so well documented that the ability of PSH and especially Housing First programs to house and retain tenants is now pretty unassailable. Most of the reports cited below for their health and well-being outcomes also report housing success, which falls within the range of 75-87 percent still housed after one year.

1.2.1. Reduced Use of Drugs and Alcohol

Several studies report reductions in PSH tenants' use of drugs and alcohol during their time in housing. These include:

- National Center on Family Homelessness (2009), for the Minnesota Supportive Housing and Managed Care Pilot Project, for 343 adults (both single and in families) in Ramsey and Blue Earth Counties. Outcomes for pilot project participants showed self-reported reductions in use of alcohol and drugs.
- VA patients in the early 1990s (n=460) were randomly assigned to one of the three groups: (1) HUD-VASH, which offered both Section 8 vouchers and intensive case management; (2) case management only; and (3) standard VA care. Using multiple imputation statistical methods to account for the missing observations (which were usually missed appointments), significant benefits in reduced abuse of drugs and alcohol were found for those assigned to HUD-VASH compared to the other two groups (Cheng et al., 2007). Also of note in this study is that results were better for people who had more contact with the assistance offered by the VA.
- Among Project 50 tenants in downtown Los Angeles, 86 percent of the 22 individuals with addiction issues were in treatment and/or using fewer drugs, per case records (LAC DMH PowerPoint).
- Srebnick (2008), examining the experiences of 20 frequent users of health services who moved into PSH in Seattle, Washington, found that, when interviewed, they agreed with statements that they were not using drugs as much as they had before moving into housing, although case notes indicated that about as many had increased their substance use as had reduced it.
- Residents of 1811 Eastlake in Seattle, who were offered PSH because they were frequent users of alcohol-related emergency room care, detoxification/sobering facilities, and jail reported reduced alcohol consumption and fewer days of drinking to intoxication after they were housed (Larimer et al., 2009, n=75).
- Perlman and Parvensky (2006), reporting for the Denver Housing First Collaborative, note that 15 percent of their sample had documented reductions in substance use.

1.2.2. *Mental Health Symptoms or Status*

- National Center on Family Homelessness (2009, methodological details above), found that during follow-up interviews, adult participants self-reported an average reduction of one symptom from intake to the end of the follow-up period. While this result may appear small, that symptom was often a big one such as going from hearing voices frequently to never.
- Assessment of the impacts on participants of receiving PSH through the first 11 projects funded by the HUD/HHS/VA Chronic Homelessness Initiative (Rosenheck and Mares, 2009) found reduced psychiatric symptomatology during

the study's four years of follow-up. Data were collected through formal interviews with participants as part of a national evaluation of the 11 projects run through VA.

- Schwarcz et al. (2009), examining outcomes after housing for 106 people with AIDS and comparing them to 39 similar people on the waiting list for housing through the Department of Public Health's (DPH's) Direct Access to Housing (DAH) program in San Francisco, found better adherence to antipsychotic medications as documented by clinic records.
- Perlman and Parvensky (2006) report that 43 percent of the sample they followed, of participants in Denver's Housing First Collaborative, had improvements in their mental health status documented by clinic records.

1.2.3. Improved Physical Health

- Mondello et al. (2009) found that PSH residents in rural Maine (n=163) self-reported improved physical health following their move into housing, compared to their own self-reported health status while homeless. The same was true for the 99 PSH tenants in the companion study done in Portland (Mondello et al., 2007).
- Srebnick (2008), in the report cited above, found that PSH tenants agreed with statements that their physical health had improved since move-in.
- No change in physical health conditions was found for Minnesota Supportive Housing and Managed Care Pilot Project Participants (National Center on Family Homelessness, 2009). Data were self-report obtained through initial and follow-up interviews.
- Schwarcz et al. (2009), in the article cited above, found greater glucose control among diabetics, and better adherence to antiretroviral medications, both documented in clinic records. Markedly better control of diabetes and other chronic conditions was also an outcome for the integrated service team serving street-homeless single adults at the Center for Community Health in downtown Los Angeles (County of Los Angeles, 2010, Attachment B, p. 15)
- Perlman and Parvensky (2006) report that 50 percent of the sample they followed, of participants in Denver's Housing First Collaborative, had improvements in their physical health status that were documented in clinic records.

1.2.4. Improved Quality of Life

- PSH tenants studied by the National Center on Family Homelessness (2009) during their participation in the Minnesota Supportive Housing and Managed

- PSH tenants in rural Maine reported significantly improved quality of life from before to after PSH placement on all six dimensions measured during client interviews, which included work, learning, health, relationships, understanding of self, and independence (Mondello et al., 2009).
- Perlman and Parvensky (2006) found that 64 percent of the sample they followed, of participants in Denver's Housing First Collaborative, self-reported improved quality of life.

1.2.5. HIV/AIDS-Related Impacts

The most recent contributions to understanding the value of PSH come from the burgeoning research on the relation of housing to the well-being of people with HIV/AIDS. Local studies (e.g., Schwarcz et al. for San Francisco) and two large random assignment studies--the Chicago Housing for Health Partnership (Buchanan et al., 2009) and the Centers for Disease Control and Prevention's three-city Housing and Health study (Wolitski et al., 2009)--as well as a longitudinal study in New York (Aidala et al., 2007), document the impact of housing on health. Wilkins and Bamburger (2009) summarized this recent literature and its implications for the White House Office of National AIDS Policy. It provides substantial evidence that housing improves access and adherence to evidence-based standards of care, reduces viral load and mortality, improves immune systems, and reduces high risk behavior associated with HIV transmission, thereby safeguarding other people's health.

1.2.6. Caveats

As with the data on cost offsets and potential savings, the evidence for impacts on PSH tenants requires some caveats.

- Less evidence of health and mental health impacts exists, or at least less has been reported in published and unpublished literature, than is true for cost impacts. Further, while some studies used clinical records and judgments to assess change, others rely on (or at least report) only self-reported data. They either interview tenants at baseline to reflect pre-housing status and later on to reflect post-housing status and compare the two, or simply ask at some time after housing whether the tenant perceives a change in status on the various dimensions of impact. These data are thus somewhat less "solid" than the cost data, which come from administrative records, but nevertheless reflects the reality as perceived by the people most affected.
- It is difficult to develop a consistent picture of outcomes related to health and well-being across studies, as the studies vary so greatly in the size of their samples, the methods they use, the outcomes they measure, and the tools they

use to measure specific outcomes. The available reports also vary considerably in their reporting of null results and negative results, so a reviewer cannot say with confidence that on balance, results are positive across studies.

- When projects are designed to take the sickest people and those with the most complex health problems, as is the case with many of the projects that have been evaluated and whose results are presented above, one cannot guarantee improvements in health across the board. Some PSH tenants in these projects die, as their health conditions were, indeed, dire. Others will improve, but perhaps not immediately. For projects with a longer time frame for follow-up, second-year results tend to be better than those for the first year, or the first six months.
- Many of the available studies focused on cost outcomes; some did not measure tenant outcomes at all, while others did, but not extensively. To the extent that one chooses to interpret substantial reductions in emergency department, inpatient, ambulance, and other emergency care as indicative of improved health status, one may, and one will probably be correct much of the time. But it is also true that these PSH tenants, once they are in housing, have other ways to get their health care needs met, so their conditions may persist while they receive assistance from on-site or clinic/outpatient-based health and behavioral health staff. Quite a few studies cite a pattern of increased use of outpatient care following housing placement.
- Only one or two studies examine the issue of “dosage,” or *how much* care PSH tenants receive once housed. One study that did this, Cheng et al. (2007), found positive effects for tenants that connected more regularly with staff and case workers. The second study (Flaming et al., 2009) found definitive effects for the payoffs of more intense services for the PSH tenants with the most complex health and behavioral health needs.

1.2.7. Implications for HHS/ASPE

- The greatest reductions in use of emergency public services are obtained when the sickest people receive PSH, but such targeting may make it harder, or at least slower, to achieve improvements in health outcomes.
- Extensive previously-untreated illnesses and health conditions among the people who become PSH tenants suggest the need for much greater attention to developing mechanisms for reaching people who are homeless with health care and connecting them to caregivers through the development of relationships of trust. All presenters at the October 21, 2010 Centers for Medicare and Medicaid Services (CMS) listening session, organized by the U.S. Interagency Council on Homelessness, emphasized the issue of trust repeatedly.

- Improvements in health conditions are clearest in the studies focused on people with AIDS, perhaps because the condition is relatively similar across the people being studied, the health markers (T4 counts, viral loads) are so clear, the treatment is also very clear, and clinicians have been involved in gathering the data.
- Better studies are needed of health and behavioral health outcomes for PSH tenants before firm conclusions can be drawn. By “better,” we mean more consistent measurement, bigger samples or pooling PSH tenants from many projects so the final sample is bigger, and comprehensive reporting so null and negative findings are clear.
- “Better studies” also means major attention to the issue of dosage, in two senses. One sense is trying to learn “how much is enough, how little is too little” with respect to seeing effects on health and well-being. The other sense is trying to understand the payoffs in terms of reducing use of crisis public services of offering more intensive, albeit expensive, services to people whose needs are very complex.

2. HOW IT IS DONE: HOUSING MODELS, MEDICAID FUNDING

We first describe the housing models in common use today as *housing*, looking only at how the housing is configured, and then examine the ways that services are attached to that housing and the funding sources that are used to pay for those services. The section ends with an examination of ways that Medicaid may be used as a funding source, noting circumstances in which only certain types of providers are able to offer services supported by Medicaid.

2.1. Housing and Service Models

2.1.1. Housing Configurations

Four housing configurations for PSH are in common use today (Burt, 2008; Locke, Khadduri, and O'Hara, 2007):

- **Single-site, all-PSH building**--project operates in only one building, usually of many more than eight units; all units occupied by project participants.
 - Buildings may offer complete units (including kitchen and bath) that are efficiencies, one-bedroom, or larger (for families), or incomplete units (kitchen and bath facilities in the hall, shared with other units--often known as Single Room Occupancy (SRO) accommodations).
 - Newer projects are creating complete units, as there is some evidence that tenants are happier in and thus remain longer in complete units compared to SRO units (Schwarcz et al., 2009). The presence of on-site staff also appears to improve housing retention for tenants with long histories of homelessness and/or complex health conditions (Burt, 2007; Schwarcz et al., 2009)
- **Single-site, mixed-use building**--project operates in only one building, usually large, in which project participants occupy only a minority of units; can be accomplished through set-asides, master leasing, or other arrangements.
 - Buildings may have both capital and operating costs supported by public monies, as are Section 202 buildings for the elderly and Section 811 buildings for people with disabilities; affordable because public capital was used to construct or rehabilitate them, as are buildings supported by Low Income Housing Tax Credits, or market rate, with the rent dependent on what local providers can negotiate.

- **Scattered-site**--usually these projects place tenants in apartments scattered throughout a community, but may also house a few tenants in units scattered throughout a large apartment building. May operate in partnership with Public Housing Authorities (PHAs) to access tenant-based rental assistance, including both Housing Choice Vouchers (HCV) and homeless-specific Shelter + Care (S+C) certificates.
- **Clustered-scattered**—project operates two or more small buildings of no more than six or eight units, and sometimes as few as 2-4 units; all units are occupied by project participants, with project buildings usually on different blocks but in close proximity.
 - Often each building was developed as a separate project because capital was procured one building at a time, but the operating agency runs them in a uniform way, and prospective tenants are placed in the first unit that opens, regardless of the building where it is located.

The approximate distribution of these PSH configurations is not known nationally, but one can get an idea from the findings of a 2007 survey of PSH in six communities (Connecticut, Los Angeles, Maine, Portland/Multnomah County (Oregon), Rhode Island, and Seattle/King County (Washington)). Burt (2008) drew a sample of 130 PSH projects from these communities, stratified by project size. Results, weighted to represent all PSH projects in the six communities (containing approximately 14,000 beds) indicated that 57 percent of beds were found in all-PSH buildings, 18 percent in mixed-use buildings, 18 percent in scattered-site apartments, and 7 percent in clustered-scattered configurations.

It is likely that a relatively smaller proportion of PSH nationwide is found in all-PSH buildings, as the communities in this study had long histories of developing all-PSH buildings and had created funding streams and policy commitments that facilitated doing so. Once communities began to use S+C certificates starting in 1993, which provide tenant-based rental assistance, scattered-site housing models began to proliferate. The recent availability of VASH vouchers also extends resources for scattered-site approaches.

2.2. Models for Connecting Services with Housing

As with housing models, there are only a limited number of ways, in practice, that services come together with formerly homeless persons living in PSH. We save for discussion in a later section the important issues of whether and how Medicaid funding plays a role in supporting the services and concentrate here on the service configurations themselves, which are complicated enough. We describe the most common configurations and give examples of each. Please note that very little in the service world is a pure type; the examples are essentially the configuration being discussed, but there will be minor exceptions for each. Also note that the older and

more established the agency, the more likely it is to have expanded by incorporating one or more alternative service-housing configurations into its portfolio, as opportunity and funding offer and as evidence mounts for the effectiveness of newer models.

Configurations include:

- **One agency does it all or almost all**--a single agency runs the housing and also provides the bulk of the services, including case management and care coordination.
 - **Central City Concern (CCC), Portland, Oregon.** CCC offers more than 1,500 units of housing, most of which is PSH. About 60 percent of its housing is alcohol-and-drug-free and the rest follows a low-barrier Housing First approach. CCC runs the housing, provides on-site staff and case managers, operates an FQHC (Old Town Clinic) that serves the larger local community as well as CCC tenants, offers addictions recovery, mental health, dental, and pharmaceutical services in an integrated care structure, runs a recuperative care program in conjunction with five local hospitals, and operates a One-Stop Career Center (a Department of Labor designation) offering a full range of employment services. CCC also does outreach related to addictions (e.g., addicts leaving the jail).
 - **So Others Might Eat (S.O.M.E.), Washington, D.C.** S.O.M.E. offers “dry” (alcohol-and-drug-free) housing to single adults (over 250 units) and families (43 units), most of which is PSH (the rest is affordable, but for people who do not need services, including program graduates). People find their way to S.O.M.E. housing through the agency’s extensive meal programs, its emergency services (showers, laundry, mail, and so on), its full-service health clinic, its employment program, and through referrals from other agencies. Many tenants of the agency’s PSH arrived there following participation in one or more stage of S.O.M.E.’s addictions recovery programming. Primary care, mental health care, addictions recovery, eye and dental care, are all available through the same agency in an integrated care model.
- **Two agencies do it (almost) all**--a partnership exists, in which a housing agency runs the housing component and a service agency supplies most of the services.
 - **A Community of Friends (ACOF) and Housing Works, Los Angeles, California.** This is a recent but expanding partnership. ACOF has long been a housing developer specializing in affordable housing for people with mental illnesses. It originally expected to provide the housing management and on-site support services needed by its tenants through a subsidiary property management company. In the last decade, however, while retaining the property management company for building operations, ACOF

has begun to partner with service agencies either as part of the plans for developing new buildings or after the buildings are already developed. The partnership with Housing Works began as an after-the-fact arrangement in one building and has been spreading to tenants in additional buildings. Housing Works specializes in assisting people with mental illnesses and co-occurring disorders. Its staff members provide tenants with comprehensive support services and also link tenants to the range of services they might need and continue to work with tenants to assure that they are getting what they need.

- **West Humboldt Park (WHP) Family and Community Development Council, Interfaith Housing Development Corporation of Chicago (IHDC), and Interfaith Council for the Homeless (ICH), Chicago, Illinois.** IHDC and WHP were partners in developing Sanctuary Place, which provides PSH for homeless women and mothers with special needs, including HIV/AIDS, chemical dependency, and/or mental illness. ICH provides a full array of on-site services to all tenants, including mental health counseling, substance use consultation, individual case management, general therapy, and job training. Counseling space, tenant meeting rooms, and staff offices occupy the ground floor. Tenants may also take advantage of a large garden and playground.
- **The Key Program: A Partnership between North Carolina’s Department of Health and Human Services (NCDHHS) and Housing Finance Agency (NCHFA).** North Carolina has a unique partnership between its NCHFA and NCDHHS that generates hundreds of housing units for persons with disabilities and supports its tenants with rent subsidies. Housing units are in developments financed in part with Low Income Housing Tax Credits, for which NCHFA imposes a requirement that 10 percent be set aside for persons with disabilities. Through this mechanism, North Carolina went from having 36 supportive housing units in 2002 to more than 2,000 funded units as of 2009. More than 800 units were open and occupied by the end of 2009, with the rest in the pipeline. In addition to the 30 percent of income that tenants pay for rent, housing costs are supported by state appropriations for the program, which is known as the Key Program.

A big challenge in implementing a supportive housing development strategy such as North Carolina’s is how to assure that qualified tenants--those with major disabilities who are homeless or at imminent risk of homelessness--get into the newly created units. Housing developers do not usually have extensive contacts with either behavioral health or homeless service providers, yet these providers are the ones who know the people who should be top priority for the new units. Recognizing that the set-aside units would not actually be *used* for qualified tenants unless developers are faced with a reliable stream of such tenants, NCDHHS created a network of

“approved referral agencies” for proposing appropriate tenants, as well as staff within NCDHHS to administer the Key Program and provide strategic support with all aspects of the program. North Carolina has committed state-funded staff positions to assure that this support is available, and has also used federal grant monies. The marketing and outreach that these staff members do with local human service providers have increased the links between mainstream services and McKinney-funded homeless programs.

To be eligible for the Key Program, a person must have a stable source of disability income and reliable supportive services. In some circumstances, people who are homeless with disabilities are eligible even if they do not yet have disability income but are in the process of applying and have a named representative who is committed to continuing with the application until it succeeds. Supportive services are assured by limiting eligibility to people who are already clients of a community-based service provider, and therefore already receiving or entitled to receive supportive services. Any approved referral agency may refer a client from within the geographical limits of its service capacity to NCDHHS for the Key Program, but it must have a clear commitment to provide the tenant with services that will be sufficient to keep people in housing. Tenants like the mixed-use nature of the NCHFA buildings because they can blend in. Their continuation in housing is not contingent on compliance with service demands. This has been a sea change for many service providers in the mental health system, but converts are starting to appear in the services world.

- **A housing agency is the center**--a housing agency runs the housing, and each tenant has his/her own relationship with a care coordinator/service agency, so there may be several service agencies supporting different groups of tenants in the building.
 - **Logan Place, Portland, Maine.** Logan Place was the first “Housing First” PSH in Maine. It was developed and is operated by a non-profit housing developer. Its conception and development was a combined community effort, and most of its tenants come from the community’s emergency services center, Preble Street. All tenants have mental illnesses, and most have co-occurring disorders including substance abuse. No single service provider supports all of Logan Place’s tenants. Each has had help applying for SSI and/or becoming a non-categorical beneficiary of Maine’s Medicaid program. Each tenant has his or her own relationship with a service provider, and several mental health agencies provide services to different subsets of the building’s tenants. Tenants receive primary care and substance use-related care through a HCH program.
 - **Community Housing Network (CHN), Columbus, Ohio.** CHN began as a housing developer during early efforts in Ohio to demonstrate the value of PSH for people with mental illness. Now, almost 20 years later, it operates

over 1,000 units of housing, most of it PSH. It manages all of its properties and provides on-site support for its tenants. Its housing staff members coordinate with over 40 service agencies in the Franklin County community to assure appropriate supports and services to its tenants, most of whom have come from homelessness. In addition to coordinating primary, mental health, and addictions care with community agencies, CHN runs its own employment and training program, and offers employment opportunities to many of its own tenants in addition to helping them prepare for employment in the wider community.

- **ZION Development Corporation, Rockford, Illinois.** ZION developed and runs the Grand Apartments, Rockford’s first PSH facility, offering 45 efficiency apartments to adult men and women who were homeless. On-site social services are provided by two Resident Services Coordinators (ZION employees), who provide case management to all residents to help them identify aspects of their lives that may have put their housing at risk in the past and to define their own personal “pursuit of purpose” plan. The Grand Apartments also collaborates with many community service agencies to assist tenants, including Crusader Clinic, which is located one block away and provides free medical evaluations and affordable health care to every resident as well as serving the Resident Services Coordinators; Janet Wattles Mental Health Center; Rosecrance Health Systems (addictions treatment); and Promised Land Employment Services (employment assessments and job search training).
- **A service agency is the center**--a single agency has the clients and provides the services, and negotiates with different housing providers (usually private landlords) to get its clients into apartments. The service agency often works in partnership with a PHA or another public agency which administers tenant-based rent subsidies such as S+C, HCVs (Section 8), or rental assistance funded by states or local governments.
 - **San Fernando Valley Community Mental Health Center (SFVCMHC), California** (one among the many mental health centers that participate in PSH in this way). SFVCMHC serves a population with SPMI that not uncommonly has co-occurring substance abuse and other disorders. Until recently its primary approach to providing permanent housing for its homeless clients has been through rental assistance vouchers (usually S+C certificates or “homeless Section 8” vouchers from the local housing authority). In the last few years the center has added a commitment to supplying the supportive services to tenants in specific single-site PSH projects, in partnership with another agency that develops and operates the building, thus putting it also into the category of “two agencies do almost all.”

- **Heartland Health Outreach, Inc. (HHO), Chicago, Illinois.** HHO opened Pathways Home in 2000 to provide residential and outpatient services to people who are homeless, seriously mentally ill, and have a substance use disorder. Pathways Home partners with the city and state to weave together services funded by Medicaid and housing funded by HUD for 50 clients. HHO provides primary health care, oral health care, and a full range of mental health and addictions treatment services. Pathways Home services are predicated on Housing First strategies and include motivational interviewing, integrated dual-diagnosis treatment, a trauma-informed approach, and the cross-training and co-location of multidisciplinary staff.

HHO uses “integrated biopsychosocial assessment” lays the framework for an integrated treatment plan that documents goals and objectives related to physical health problems, mental health needs, substance use concerns, and social and environmental issues. Once a need for psychiatric and primary care services is determined, staff co-located at a single site provide those services and also serve as cross-trainers, enhancing the residential staff’s ability to respond to medical and psychiatric crisis. As participants living at Pathways Home avail themselves of outpatient services and psychiatric services, all of their services are documented in an electronic health record that allows staff across settings to share information. An additional benefit of the electronic record is the ability to bill Medicaid quickly and efficiently.

- **Several agencies work as a team**--several agencies, which may be any combination of public, non-profit, and for-profit, work as a team to support PSH tenants, who may live in single-site or scattered-site housing situations. The integrated services approach exemplified by the collaborative described in this housing/services configuration is also found in other service configurations. CCC and S.O.M.E. offer integrated services within a “one agency does it all” approach, and HHO does so within a model with the service agency at the center.
 - **Direct Access to Housing (DAH), San Francisco, California.** Established in 1998, the San Francisco DPH's DAH program provides PSH with on-site services for approximately 1,200 formerly homeless adults, most of whom have concurrent mental health, substance use and chronic medical conditions. Over the years of its existence, DAH has found itself in several different housing services configurations, but in recent years has increasingly participated in integrated housing service structures. DAH partners with several non-profit housing development and property management agencies (Mercy Housing, Tenderloin Neighborhood Development Corporation, Developing Innovations in Supportive Housing, several non-profit behavioral health agencies (Conard House, Catholic Charities CYO, Glide Church, and Lutheran Social Services), and other local government agencies (Mayor’s Office of Housing, San Francisco Human Services Agency).

Housing: DAH is a "low threshold, housing first" program that accepts single adults into permanent housing directly from the streets, shelters, acute care hospitals or long-term care facilities. The program targets "high-utilizers" of the public health system. Currently, public health services through DAH and its partners support over 1,200 PSH tenants in 27 housing sites ranging in size from 33 to 106 units. The housing sites, operated by several housing partners, take a variety of forms including one licensed residential care facility; master leased SRO hotels; newly-developed PSH buildings; and units that are set aside for DAH use in larger residential buildings. While residents have access to 24-hour staff and voluntary on-site services, each tenant lives independently in his or her own unit. Approximately 650 more units are expected to be in use by 2013.

Medical services: All housing associated with DAH has some medical staff on site, ranging from once-a-week public health nurses to full-time nurses, psychiatrists and part-time nurse practitioners. Most on-going care is provided at the Housing and Urban Health (HUH) clinic. Located on the ground floor of one of the PSH projects that DAH serves, the HUH clinic is the primary care provider for most DAH tenants. The clinic serves approximately 1,100 clients a month, with 10 percent of service encounters occurring as home visits at supportive housing sites. The HUH clinic is a FQHC (see below) with a per visit billable rate of approximately \$202 as of August 2010. The clinic is staffed primarily by advanced practice clinicians (nurse practitioners and physician assistants), but also supports three full and part-time psychiatrists and a full-time medical director. Medical staff from the HUH clinic and all supportive housing sites meet at least monthly with the medical director for the DAH program to assist with medical treatment plans and to strategize on how to access appropriate medical and psychiatric care in the community.

Case management services: All supportive housing sites associated with DAH have between three and six on-site case managers, as well as a site director. Case managers help residents obtain and maintain benefits, provide individual case management for substance use and mental health problems, provide life skills and family counseling, assist in accessing medical and behavioral health treatment, assist with accessing food and clothing, and interface with property management to prevent eviction.

Behavioral health services: The HUH clinic works closely with behavioral health specialists serving DAH residents. Additionally, for tenants of the Human Service Agency's Housing First Program (one of DAH's housing partners), the HUH clinic has partnered with the Citywide Behavioral Health Roving Team, made up of at least three behavioral health specialists, to engage them in their homes and then help them access on-going care in the clinic. The primary goal of the Roving Team is to prevent eviction resulting

from exacerbation of mental health and substance use disorders. To make this happen, the team is available five days a week for rapid intervention and placement of residents in off-site mental health or substance use residential treatment. During the time of residential treatment, tenants' permanent housing is held for them.

- **Lifelong Medical Care, Oakland and East Bay, California.** LifeLong Medical Care is a FQHC (see below) and has served low income communities in Berkeley and Oakland California for 35 years. LifeLong provides care to more than 22,000 individuals per year through six primary care clinics, two adult day health centers, supportive housing, and a dental clinic. LifeLong's integrated care model promotes a collaborative, person centered approach to physical, psychosocial and spiritual issues with the goal of achieving positive health outcomes, independent living, recovery and improved quality of life.

All of LifeLong's integrated care models share a number of features, including multidisciplinary, co-located teams of staff including primary care providers, licensed clinical social workers (LCSWs), psychiatrists, psychologists, case managers and medical assistants; regular team meetings to case conference and manage care; shared medical records; client goal directed care; and primary care and mental health cross-training.

LifeLong is a partner in several PSH programs, providing care for about 450 formerly chronically homeless residents of single-site supportive housing programs and another 75 similar tenants in scattered-site housing. LifeLong does not provide housing or mental health care itself, but partners with PSH projects and agencies and mental health providers.

- **Project 50, Los Angeles, California.** In December 2007, 140 people living on the streets of Skid Row were identified as highly vulnerable using Common Ground's Vulnerability Index. Of these, 41 percent had three or more hospitalizations in the year before accepting housing, 31 percent had three or more emergency room visits *in the three months* before accepting housing, and 55 percent had three or more serious illnesses or conditions. Housing offers began with the 50 people deemed most vulnerable. The first person was housed on January 29, 2008, and 49 were housed within 10 months of the first move-in. On average each individual had been homeless almost 10 years. Despite their long histories of homelessness and illness, *everyone* who was offered housing through Project 50 accepted.

Integrated care structure: The integrated service structure developed for Project 50 involves numerous public agencies and other partners. County agencies include the departments of Public Health (DPH), Health Services (DHS), Mental Health (DMH), Public Social Services (DPSS), and the Sheriff, with the County Executive Office overseeing the entire operation.

City of Los Angeles agencies include the mayor's office and police department. The Housing Authority of the City of Los Angeles provides rent subsidies. Services come from many agencies, such as mental health treatment (DMH), health and medical treatment (DHS), housing (Skid Row Housing Trust), substance abuse treatment (DPH), SSI and Medicaid eligibility assistance (DPSS, Volunteers of America). DMH supplies staff as case managers. Members of the Integrated Supportive Services Team come from DMH, DHS, DPH, and DPSS. The Sheriff's Department is a resource for recruiting participants through the jail mental health unit and its Community Reintegration Project. The John Wesley County Hospital (JWCH) Institute, a FQHC working under a contract administered by DHS, provides primary care, pharmacy, and other critical aspects of care. The Didi Hirsch Community Mental Health Center (CMHC) is the partner supplying much of the substance abuse treatment for Project 50 clients, under a contract with DPH. Finally, the VA provides care to Project 50's veterans.

Braided funding: The most critical aspect of this demonstration project was the braided funding and learning to leverage and maximize existing funding and other resources. The FQHC (JWCH) set up a satellite clinic on-site in one of the Skid Row Housing Trust buildings where Project 50 participants were housed and was also certified as a DMH provider. Since the residents are extremely vulnerable, Medicaid was secured for most within a few months of securing housing and covers much of the health and mental health services that JWCH provides. Although billing the substance abuse treatment through the Drug MediCal program has not yet been possible, the county's Substance Abuse Prevention and Control agency has provided the funding for on-site substance abuse treatment through existing contracts with service providers.

Project 50 has been a resounding success, both in its ability to identify, connect with, house, and keep housed some extremely vulnerable people with long histories of homelessness and in the documented impact that housing these people has had on reducing their use of crisis public services (Flaming et al., 2009; LAC DMH PowerPoint). As a result, replications involving more than 500 additional PSH units and tenants are under way, relying on the integrated service networks developed during the demonstration.

- **Boston HealthCare for the Homeless Program (BHCHP), Boston, Massachusetts.** BHCHP began in 1984 as a coalition of health care professionals, homeless service providers, and elected officials. It became a tax-exempt non-profit agency in 1988 and was designated an FQHC, which allows it to receive reimbursement for services from Medicaid and Medicare. BHCHP provides services at more than 80 locations, including PSH, transitional housing, emergency shelters, and the streets, as well as in

clinics, hospitals, and other medical settings. Through this network, BHCHP delivers direct care and connects patients with the full range of services that they need. It operates through multidisciplinary teams consisting of physicians, physician assistants, psychiatrists, mental health clinicians, nurse practitioners, registered nurses and case managers.

BHCHP's goals are: (1) to integrate health services for people who are homeless in shelters and on the streets with the care offered in Boston's traditional health care system; and (2) to be a catalyst within the traditional health care system, making services more accessible and responsive to the needs of homeless patients. BHCHP integrates its care with Boston's academic medical centers and CHCs by operating clinics on the campuses of Massachusetts General Hospital and Boston Medical Center.

The patient centered comprehensive care provided by BHCHP is able to follow people first encountered, engaged, and treated on the streets or in shelters as they move into more stable housing situations including PSH. It takes into account the complexity of disease that results from years of living on the streets and in the shelter system. Often medical disease is complicated by untreated mental illness and challenging addictions. The addiction and behavioral health issues must be addressed; otherwise chronic disease management will likely fail. For example, treating high blood pressure in a depressed patient who uses alcohol is often unsuccessful. The high prevalence of behavioral health issues in the homeless population has led BHCHP to set up clinical sites where medical services are highly integrated with behavioral health services. At its largest clinic site, a patient may have dental, behavioral health and medical needs addressed in one clinical space. This co-location of care takes away some of the barriers and provides a more efficient system. It also allows team members to meet with patients together and discuss patient plans more effectively. It is made possible by a capitation funding structure under Massachusetts' almost universal health insurance plan.

2.3. Types of Medicaid Funding That May Be Used for PSH Clients

The following summary of current strategies for using Medicaid to pay for services in supportive housing reflects a synthesis of published literature, initial telephone interviews with key informants, and the previous experience of the Abt research team members. We expect to obtain additional information regarding current practices and emerging strategies during our site visits and through supplemental telephone conversations with selected jurisdictions.

The two primary strategies for using Medicaid to finance services in supportive housing are addressed in Section 2.3.1 and Section 2.3.2. They are:

- Using the Medicaid Rehabilitation (“Rehab”) Option to provide community mental health services linked to PSH; and
- Having FQHCs provide services reimbursed by Medicaid to PSH residents. FQHCs may be CHCs or HCH programs.

Other strategies are less commonly used to provide Medicaid-funded services in PSH, but have been used in some states. Covered briefly in Section 2.3.3 and Section 2.3.4 are:

- Services covered under the Medicaid Personal Care Option; and
- Services provided under the Home and Community-Based Services Waiver (HCBS or 1915c waivers).

Services in PSH may also be financed in part through the Targeted Case Management Option. Outreach to identify vulnerable chronically homeless individuals who need PSH and help them access Medicaid benefits may be reimbursable as a Medicaid Administrative Activity. The authors do not discuss these Medicaid financing mechanisms in more detail, because little documentation exists of their use in PSH. In our initial phone interviews, we have heard that a few providers use these approaches. In our site visits, we will seek to get more information.

Cutting across these strategies for using Medicaid to fund services in PSH and linked to PSH residents is the growing use of managed care or capitation financing for Medicaid-funded behavioral health services. Managed care can create opportunities for providing an expanded range of Medicaid-funded services in PSH and is discussed in Section 2.3.5.

Finally, Section 2.3.6 describes a new federal initiative, Money Follows the Person (MFP), that may help expand Medicaid coverage of services for people who are chronically homeless living in PSH.

Some of the information provided in this section is adapted from a Handbook published by ASPE in 2005: *Using Medicaid to Support Working Age Adults with Serious Mental Illnesses in the Community*. Other sources include a CMS publication (Smith, 2007) and a report by the Corporation for Supportive Housing and Technical Assistance Collaborative (2008).

2.3.1. Community Mental Health Services Covered Under the Medicaid Rehabilitation Option

Nearly all states offer Medicaid coverage for behavioral health services under the Rehab Option, although there are significant differences among states in the scope of services they cover and in provider qualifications and financing mechanisms. Typically, services for treating and rehabilitating mental health conditions are better covered than those for substance use conditions. This holds true also in coverage that states provide for treatment of behavioral health conditions under the fee-for-service (FFS) benefit and

managed care benefits. In some states there is a “carve-out” of coverage for behavioral health services, which may be delivered through specialty managed care arrangements. These carve-outs are discussed in more detail below in Section 2.3.5. The non-federal share of costs for these services (the match) may be the responsibility of local governments, often counties.

- **Who is eligible for Rehabilitation Option services?** While federal law allows states to cover rehabilitation services as optional benefits for a broad range of medical and behavioral health conditions, in most states coverage for the types of rehabilitation services that might be delivered in PSH is limited to persons with serious mental illness (SMI), which is usually defined as persons with schizophrenia or major affective disorders. Others who may be eligible are persons with other (usually less-severe) mental health disorders who are experiencing severe crises that result in danger to self or others. This includes persons *with SMI* who also have co-occurring substance abuse problems, trauma, or medical conditions, but does not include those with serious substance abuse problems who do not have SMI.

While many homeless and low income persons *without SMI* who have serious substance abuse problems will become eligible for Medicaid in 2014 because their incomes are below 133 percent of the federal poverty level (FPL), this does not mean that they will meet the “medical necessity” criteria that determine eligibility for rehabilitation services covered as Medicaid mental health services.

- **Which mental health or behavioral health services are covered by the Rehabilitation Option?** The specific service definitions, provider qualifications, and reimbursement rates and procedures covered under the Rehab Option will vary based on the state Medicaid Plan, within the overall framework of federal rules. Generally rehabilitation services are intended to reduce physical or mental disability and *restore* a person to his or her best possible functional level. Rehabilitation services covered under Medicaid may be delivered in a range of community settings in most states, including a client’s home, and are not limited to a clinic site or treatment facility. Rehabilitation services include services that instruct, assist, and support clients in areas that include (ASPE, 2005, pp. 56-61 and 148-152):
 - **Basic living skills needed to independently function in the community**, including food planning and preparation, budgeting, household management, community awareness, and mobility skills.
 - **Skills needed to enable or maintain independent living in the community**, including interpersonal communication and socialization skills and techniques.
 - **Counseling and therapy services** directed toward the elimination of psychosocial barriers that impede the development or modification of skills

needed for independent functioning in the community, including mental illness symptom management skills, relapse prevention, crisis services that prevent hospitalization or quickly stabilize a person, peer support, medication education and management.

Depending on the provisions of the state's Medicaid Plan, services that address co-occurring substance abuse conditions for people who have SMI may not be included in the benefit design or reimbursed under the Rehab Option, although these services might be covered under other benefits. While federal law permits states to offer optional Medicaid rehabilitation benefits to address substance abuse disorders, generally state Medicaid coverage for substance abuse services is much more limited than coverage for mental health services.

Case management services may be covered as rehabilitation services as long as they are related to managing Medicaid-covered services, but case management to assist individuals to obtain non-Medicaid services is not covered.² Some of the services provided by case managers may be covered as rehabilitation services if the services focus on helping clients build or restore *skills* that have been impaired by physical or mental disability, rather than having the case manager make arrangements for the client.

Employment-related skills and supported employment may be covered as rehabilitation services to assist individuals to function in the work place, but job training and vocational or educational services generally are not covered.

Assertive Community Treatment (ACT) is covered as a rehabilitation service in some states. ACT is a model of intensive, team-based, flexible, client centered services that provide support for community living for persons with SMI--and often co-occurring substance abuse problems--who might otherwise have frequent or extended stays in hospitals. In June 1999, the Health Care Financing Administration (which preceded CMS) sent a letter to all State Medicaid Directors encouraging them to consider including ACT as a component of mental health services covered by Medicaid. Several states have also included coverage for Community Support Services as a Medicaid-covered mental health benefit under the Rehab Option. Community Support Services are less intensive than ACT, but still flexible and individualized services and supports that help a person achieve rehabilitation and recovery goals and develop coping skills for independent living in the community. Community Support Services may be provided as a step-down from ACT for clients who no longer need intensive services. We will follow up on this issue during site visits and supplemental phone calls, especially to Pathways-DC, which is making a serious effort to shift clients who have been stable in housing from ACT to lower levels of care.

² These may be covered under the Targeted Case Management option, in which case both types of case management services may be delivered by the same providers if the state Plan aligns coverage for these benefits.

Peer support services may be covered as a specific type of rehabilitation service, peer counseling, or peer counselors with appropriate training and support may be included among the types of providers who are qualified to deliver a range of rehabilitation services, such as living skills training or social support. Peer counselors may be included as members of team models such as ACT.

- **How are services funded under the Rehabilitation Option linked to housing?** PSH may be site-based, with all or a substantial share of the housing units in a building set aside for persons eligible for mental health services, or services may be linked to housing vouchers in scattered-site models of PSH. In some cases community mental health services are linked to clients rather than to housing and the services can follow the client from one housing placement to another. Several different service providers may work with tenants who live at a single PSH housing site or participate in a PSH scattered-site program.

If PSH services are funded as community mental health services under the Rehab Option and connected to a particular housing project eligibility for the PSH may be limited to persons with SMI who are eligible for the Medicaid Rehab Option services.

The combination of ACT services and scattered-site PSH using tenant-based housing subsidies is a model frequently used to provide PSH for people who are chronically homeless. Modified ACT services are sometimes used in site-based PSH.

- **Which types of providers deliver services under the Rehabilitation Option?** States have significant flexibility to establish provider qualifications and reimbursement mechanisms within the overall requirements of federal law. Generally, states include:
 - **Licensed Practitioners of the Healing Arts (LPHA):** psychiatrists, psychologists, LCSWs, registered nurses, and advance practice nurses. LPHAs are authorized to recommend services. States interpret this to mean LPHAs are involved in evaluation and diagnosis, development and/or approval of each client's service plan, and on-going review to determine the continued need for services. Federal law and regulations do not require that the LPHA deliver the rehabilitation services directly.
 - **Other qualified mental health service providers:** peer counselors or other personnel with a combination of training and experience, working under appropriate clinical supervision. States establish qualifications and licensing or certification requirements, if applicable.
- **How does Medicaid reimbursement work under the Rehabilitation Option?** In recent years CMS encouraged or required billing for specific, covered rehabilitation services in discrete time increments (e.g., 15 minutes) and

discouraged “bundling” a package that might include several covered services to be reimbursed on a daily or monthly rate. The authors will be gathering additional information during site visits and supplemental key informant calls to learn more about bundling in state and county Medicaid programs.

Federal policy direction to states regarding Medicaid reimbursement for rehabilitation services has been evolving, and has at times been in turmoil. In August 2007, CMS published a Proposed Rule for Coverage for Rehabilitative Services (72 FR 45201) designed to “clarify” the definition of “rehabilitative services,” narrowing coverage and increasing documentation requirements under the Medicaid program. Many mental health providers and stakeholders responded to the proposed rule with comments and concerns, and as a result of widespread opposition Congress enacted a moratorium on the proposed rules, which were later withdrawn by the Obama Administration.

2.3.2. Federally Qualified Health Centers (FQHCs): Community Health Centers (CHCs) and HealthCare for the Homeless (HCH) Programs

In a wide range of communities across the country, CHCs or HCH programs are delivering services to PSH tenants and receiving Medicaid reimbursement as FQHCs. States must cover services that are furnished by FQHCs under their Medicaid programs. FQHCs may also receive Health Center grant funding administered by HRSA. In many cases, services in PSH are an extension of the services of FQHCs that also include outreach to people who are homeless and living on the streets or in emergency shelters and medical care delivered in clinic settings. When this happens, PSH is intended to facilitate continuity of care for patients with complex, co-occurring medical and behavioral health needs who may find it hard to access or establish trusting relationships with more traditional medical, mental health or substance abuse treatment services.

In 2008 the National Health Care for the Homeless Council and the Corporation for Supportive Housing jointly produced a report that describes the role of CHCs in providing services to PSH tenants (Post, 2008). The following discussion draws from that report.

- **Who is eligible for FQHC services?** CHCs generally offer services to all of the residents of a low income or underserved community (or a supportive housing program), regardless of whether they are enrolled in Medicaid. The CHC may have a sliding scale for uninsured patients that adjusts fees based on income and use their federal grant funding to cover costs of care to low income patients who do not have insurance coverage. HCH programs receive federal grant funding to serve persons who are homeless, including those living in transitional housing. HCH programs can continue to serve people who are homeless for up to 12 months after they obtain permanent housing. Federal policies are ambiguous regarding the delivery of on-going services in PSH by HCH programs

to people who were previously homeless, beyond the first 12 months after they move into permanent housing.³

- **Which PSH services are covered by Medicaid funding of FQHCs?** CHCs and HCH programs deliver a wide range of health and behavioral health services in PSH FQHC reimbursement procedures provide Medicaid payments based on “billable encounters” between clients and clinicians, including physicians, psychiatrists, nurse practitioners, physician’s assistants, clinical psychologists, and LCSWs. Some states limit FQHC reimbursement to one visit per day for the same patient and do not allow billing for two or more visits during which the patient receives both mental health and medical services on the same day-- despite the fact that simultaneous visits promote the goal of integrated care.

Medicaid payment rates for FQHC visits are usually higher than rates paid for other health services, and are intended to incorporate costs for other non-licensed staff (including community health workers, and other nurses, mental health workers, substance abuse counselors, or social workers) who are part of the care team but do not bill separately.

Case management may be provided by FQHCs as an “enabling service” under federal CHC funding rules. Case management services may be provided by nurse care managers, trained mental health workers, paraprofessionals, and/or peer counselors. However, federal policy is not clearly articulated, and state policies vary when it comes to including costs for all of the staff who provide services in PSH when setting rates for FQHC services. In some states costs for supportive housing case managers or for non-licensed staff who provide substance abuse counseling have been disallowed in calculating FQHC rates, while other states allow them.

- **How are FQHC services linked to housing?** CHCs and HCH programs have used several program models to provide services to PSH tenants, including on-site clinics in supportive housing projects, home visits to clients who are living in scattered PSH sites, and clinic-based services that are designed to meet the needs of PSH tenants and delivered in coordination with housing programs. On-site services in PSH often include part-time primary care and psychiatry services delivered a few hours or days each week in space set aside in the supportive housing building as a “satellite clinic,” while full-time, site-based staff provide

³ In March 2009, HRSA issued a Policy Information Notice 2009-05 regarding requests for a change in scope to add a new target population for “special populations-only grantees” such as HCH programs. The Notice indicates that HRSA recognizes there are many reasons why a health center or HCH program might want to add a new target population to its current scope of project, and requires prior approval from HRSA if a special populations-only health center seeks changes that are considered significant, “e.g. more than 25 percent of the health center’s patient population is/will not be part of the defined target population.” This policy seems to suggest that prior approval would not be required if the number of PSH tenants served by the HCH program (who might no longer be considered homeless after living in PSH for 12 months) is less than 25 percent of the patient population served by the HCH.

case management, health education and wellness, and services to address mental health and substance problems.

In some cases, on-site case management and psychosocial support services are provided by a partner organization, and the CHC or HCH delivers mobile or “roving” medical services or home visits to PSH tenants whose health needs have been identified by case managers. In other cases the CHC or HCH program establishes a specialized clinic and/or dedicated clinic staffing for PSH tenants in a location that is easily accessible to several PSH projects in a neighborhood, and uses outreach strategies to engage PSH tenants and encourage use of the clinic for on-going health care.

CHCs generally rely on Medicaid revenues to cover only a portion of total service costs in PSH, in part because many PSH tenants who receive services are not covered by Medicaid.

- **Which types of providers deliver services?** CHCs and HCH programs receive grant funding from HRSA and qualify for Medicaid reimbursement as FQHCs. Other organizations that meet similar requirements but do not receive federal grant funding may qualify for FQHC “look-alike” status in order to obtain FQHC Medicaid reimbursements. States may have restrictions on Medicaid reimbursement for services provided by practitioners who are working under subcontractor arrangements (not employees of the FQHC) or working outside the “four walls” of a clinic operated by the FQHC.
- **How does Medicaid reimbursement work for FQHCs and FQHC look-alikes?** Federal law governs the establishment of FQHC rates. In 2000, a prospective payment system was established under federal law, replacing a previous cost-based reimbursement system. FQHCs are reimbursed based on face-to-face “billable encounters” between Medicaid beneficiaries and licensed clinicians including physicians, psychiatrists, nurse practitioners, physician’s assistants, clinical psychologists, and LCSWs. (While the costs of other staff may be reflected in FQHC rates, their services are not billed separately.) When FQHCs provide care to people who are enrolled in Medicaid managed care plans, the state may be required to pay the FQHC the difference between the established FQHC rate and the payment rate provided by the managed care plan.

2.3.3. Personal Care Services

Personal care services are designed to help persons with physical, mental, or cognitive disabilities with daily tasks that they cannot perform because of their functional impairments. These daily tasks include activities of daily living (ADLs) such as bathing, dressing, eating, toileting, and transferring from a bed to a chair and instrumental activities of daily living (IADLs) such as cooking, grocery shopping, and medication management.

Personal care services are used less frequently than the Rehab Option or FQHCs to provide Medicaid-reimbursed services linked to PSH. However, they sometimes have been used for residents of PSH, and the authors will be seeking more information on this during the site visits and in-depth telephone interviews. Performing or assisting a person to perform essential daily tasks cannot be covered under Medicaid's Rehab Option, which can cover teaching or coaching an individual in daily living skills. Therefore, it may be desirable to combine services provided under the Rehab Option with personal care services.

About half of all states offer some coverage of personal care services for Medicaid beneficiaries, and this optional benefit has been used to cover some services in PSH in at least one state (New Jersey) and maybe others. Some states have used this optional benefit to cover some of the costs of services provided in community residences for persons with mental illnesses or developmental disabilities, but not in PSH for people who are homeless.⁴

2.3.4. Home and Community-Based Waiver Services (HCBS or 1915c Waivers)

HCBS waivers are intended to provide services to individuals who would otherwise be living in nursing homes or other Medicaid-financed institutional settings. There are currently more than 350 HCBS waiver programs serving more than one million individuals nationwide. The programs may be limited to specific areas of the state or targeted to people with specific types of disabling health conditions (e.g., HIV/AIDS, traumatic brain injuries, or older adults). States also can limit the number of people enrolled in waiver programs.

To get approval from CMS for a 1915c waiver, a state must demonstrate that the proposed program will be "cost neutral"--that is, that average per person costs of operating the program will not be higher than the average cost of providing institutional and other Medicaid services to these individuals in the absence of a waiver program.

Most states do not operate HCBS waiver programs specifically for persons with SMI. It is difficult to meet the test of cost neutrality for people with SMI, since Medicaid does not pay for care in Institutions of Mental Disease. However persons with SMI may be eligible for HCBS waivers if they have functional limitations or other disabling health conditions that would meet the state's criteria for nursing home level care.

In 1999 the U.S. Supreme Court ruled in the *Olmstead* decision that unnecessary institutionalization may constitute discrimination in violation of the Americans with Disabilities Act. Many states use 1915c waivers to provide HCBS as a component of *Olmstead* compliance efforts that focus on helping people with disabilities transition from institutions to community-based settings or avoid unnecessary institutionalization.

⁴ Personal care services may also be provided in the work place, to support individuals with SMI or other disabilities who are returning to work. A few states provide coverage for personal care services in the work place.

In a few states, public policy, program development and financing efforts related to Olmstead compliance are closely aligned with efforts to create PSH for people who are homeless with disabilities. In other states these are separate and parallel efforts with little coordination or alignment. Examples of successful initiatives will be investigated during site visits and key informant interviews conducted under the broader environmental scan.

- **Who is eligible for services provided under HCBS waivers?** The population that may be made eligible for Medicaid-funded services under 1915c waivers must be persons with serious and long-term disabilities who are living in or eligible for and likely to need Medicaid-financed institutional care. Among chronically homeless persons currently on the streets or in shelters, this could include people with significant disabilities and functional impairments. This would not be limited to persons with SMI, but would likely be limited to persons who are already eligible for Medicaid and who also have very high levels of vulnerability or disability. Based on the findings from several recent studies (Heartland Alliance, 2009; Schwarcz et al., 2009), a small but growing number of chronically homeless adults are receiving care in nursing homes. This number is likely to increase as many of the most chronically homeless adults are getting older and have high rates of chronic medical conditions. Thus, a growing number of the most vulnerable chronically homeless adults could be included in the categories of people states choose to make eligible for HCBS waivers.
- **What services are covered under HCBS waivers?** Under federal guidelines, states can offer a range of services under 1915c waivers that include case management, personal care, habilitation (including teaching or helping residents maintain or improve skills related to daily living), adult day health care (also known as adult day services or adult day care), homemaker, home health aide, chore services, support coordination, and additional services and supports that help individuals to avoid institutionalization. Because states may have separate HCBS waivers for different target populations, each waiver may cover different packages of services tailored to each target group.⁵ States may not use waiver funding to cover costs of room and board.

People who receive HCBS waivers also remain eligible for other Medicaid services in addition to the services provided and financed through the waiver. Services offered under the waiver may include those that are not otherwise covered under the state's Medicaid Plan.

- **How are HCBS linked to housing?** We have identified only a few examples in which services funded by HCBS waivers are provided in PSH. However, there may be opportunities to use this approach to financing services to some of the

⁵ HCBS may also include "respite," but this term does not have the same meaning as it does when used by HCH providers or others who have established medical respite programs. Instead the term refers to care that provides a break for family members who are caring for a disabled person, so that the person can continue to live in a community setting.

most vulnerable and disabled tenants living in supportive housing projects. Services provided by nurse care managers, social workers, or other providers of individualized personal care and supports could augment the level of services provided in PSH to meet the needs of residents who are extremely frail or those who have the most complex and disabling health problems.

HCBS-funded services also might be used in scattered-site PSH, assuming that sufficient individualized support services could be made available. In San Francisco, the State of California is preparing to implement financing for HCBS delivered to some PSH tenants who reside in apartments with private bathrooms and kitchens. The state will not permit HCBS for residents of SRO PSH. The state considers that SROs with shared bathrooms and kitchens do not meet criteria for home and community-based living situations.

Another approach is a cross-disability integrated PSH model described in a report by the Technical Assistance Collaborative (2009, p. 11). In that model, community-based supportive services are linked to tenants who live in housing units that are set aside as a small percentage (usually 5-10 percent and sometimes as many as 25 percent) of units in affordable housing funded through state-allocated resources such as LIHTC and HOME. The set-aside may be a condition of state funding. The units may be supported by housing subsidies for people with disabilities who are not formerly homeless, but some may qualify for HCBS waivers because of serious and long-term disabilities and risk of institutionalization and also have histories of chronic homelessness.

While there are some important differences between assisted living and PSH, strategies for financing services in assisted living programs through HCBS waivers may have applicability for PSH. According to a 2009 report, "State Medicaid Reimbursement Policies and Practices in Assisted Living" (Mollica, 2009), 37 states use 1915c HCBS waivers to cover services in residential settings. Under waiver provisions, a range of services can be covered to support a person with disabilities to live with independence outside of larger, congregate and institutional settings, including personal care services not otherwise covered in the state plan, help with ADLs and IADLs, adult day care, and emergency respite services.

In June 2009, CMS published an advance notice of proposed rulemaking in the *Federal Register*,⁶ describing the intention to publish rules related to identifying the home and community-based character of settings in which HCBS participants reside and/or receive services. As described in the notice, CMS intends that these requirements will increase choice by providing waiver participants with notice of housing alternatives and create greater demand and market incentives for person centered residential settings. The goal is for states to identify financing mechanisms for reducing the size of existing larger residences that are provider centered and institution-like (such as Adult Homes) and transitioning to smaller, more individualized settings. This policy

⁶ See <http://edocket.access.gpo.gov/2009/pdf/E9-14559.pdf>.

direction is a better fit for preferred PSH models that rely on individual or smaller group living, but may increase competition for affordable scattered-site or smaller settings as some of the larger residential homes downsize and transfer their residents to less congregate settings.

- **Which types of providers deliver services under HCBS?** States determine the qualifications for providers of services covered under 1915c waivers. For example, a state may require that services be provided by or under the supervision of a nurse or LCSW.
- **How does Medicaid reimbursement work under HCBS?** Reimbursement mechanisms vary from state to state. Some states have established daily rates for a flexible package of services that are provided to eligible individuals through HCBS waivers. States may use “tiered” rates that vary based on the type of residential setting or the level of assistance needed by the individual. States may also establish rates that vary by region or may negotiate rates that vary by provider.

2.3.5. Managed Care/Capitation

Over the last two decades, states have been shifting the financing and delivery of Medicaid services to managed care arrangements. In recent years a growing number of states have moved to require that all (or nearly all) Medicaid beneficiaries enroll in managed care plans. In some cases states have contracted with private insurance companies or managed care organizations (MCOs), and in some cases new quasi-public or non-profit MCOs have been created. Currently a majority of Medicaid beneficiaries are enrolled in some form of managed care.

In many states, this shift began with non-disabled Medicaid beneficiaries, while seniors and persons with disabilities remained enrolled in “fee-for-service” Medicaid. An exception to the slower implementation of managed care for people with disabilities was the high rate of managed care penetration for behavioral health services. States that have shifted behavioral health services to managed care sometimes have contracted with private insurance companies or specialty behavioral health plans to take over the delivery of Medicaid behavioral health services. In other states the county or local government entity became the MCO, operating under an agreement with the state.

The “carve-out” behavioral health plans often cover a broader range of treatment, rehabilitation, and recovery support services for both mental health and substance use conditions than are available under other parts of a state’s Medicaid program. However, use of the expanded benefits usually is subject to a stricter review, than typically employed in FFS Medicaid, for prior authorization of services and on-going utilization management to determine the “medical necessity” of the care provided to the eligible individual.

Usually the state pays a fixed fee or “capitation” to the MCO to provide all of the services covered in the managed care arrangement, which may include a broad range of Medicaid-covered health services or may cover only “specialty” mental health services. The MCO may deliver care directly or contract with a network of providers. Community-based providers of health care, mental health and substance abuse services and other supports may be able to participate in the MCO provider network if they meet applicable provider qualifications. MCOs participating in Medicaid managed care may be required to contract with FQHCs.

In states with “carve-outs” services for behavioral health services are reimbursed separately from other health services, using separate rules regarding medical necessity for care, prior authorization for care, provider qualifications and reimbursement procedures.

While a full discussion of Medicaid managed care is beyond the scope of this project, it is important to note that MCOs that receive a single capitated or case rate have incentives to purchase the most cost-effective mix of services and supports and to reduce avoidable costs for hospital care. Capitation may provide the flexibility to shift spending from hospitals and emergency care to community services and MCOs may have the flexibility to use their funding to pay for alternative services that can produce savings in other health care costs while improving outcomes for clients.

With the flexibility that waivers afford states to pay for services that are otherwise not covered under mandatory or optional provisions of the Medicaid program, some Medicaid managed care plans have been able to implement strategies to reduce avoidable hospitalizations and reinvest savings into PSH. The investment in PSH, including costs associated with planning and implementing supportive housing programs for people who are homeless and are enrolled in Medicaid managed care, serves to stabilize living conditions and health status for the eligible individual, in turn reducing future costs for their behavioral health and medical care. Other Medicaid managed care plans are focusing attention on the small number of individuals who have high costs for frequent and avoidable visits to hospital emergency rooms or for inpatient hospital stays, and are designing and implementing new models of care coordination and individualized services and supports that may include linkages to housing or paying for services in PSH.

Managed care plans cannot be used to pay for the operating costs of PSH. A report published by CMS (Smith, 2007) indicates that “Federal Medicaid law does not permit states to claim federal financial participation in the costs of ‘room and board’ (shelter, food, and other routine living expenses) associated with the delivery of a service except in Medicaid-reimbursable institutional setting such as nursing facilities. ... The costs of room and board must be met from a beneficiary’s own resources and/or other federal, state and local programs.”

2.3.6. A New Federal Initiative: Money Follows the Person (MFP)

The MFP Demonstration is a federal initiative created by the Deficit Reduction Act that is designed to help states make changes to their Medicaid-funded long-term care support systems. MFP's goal is reducing reliance on expensive institutional care by expanding the availability of more cost-effective community supports for seniors and people with serious disabilities. The program's primary strategy is to target individuals with disabilities who have been residing in institutions and transition them to the community with supportive services. Section 2403 of the Affordable Care Act extends the program for five years and addresses expanded use of MFP. The initiative seeks to "re-balance" Medicaid spending on long-term care in nursing homes and care delivered in home and community-based settings. MFP provides enhanced federal funding for the cost of care for the transitioned individuals (for 12 months) and for the community-based long-term supportive services. MFP does not create a new Medicaid authority, but rather makes resources available to states to help with re-designing and implementing changes in Medicaid benefits, service delivery systems, policies and procedures to help people move from (or be diverted from) institutional care to living in community settings. Services likely to be covered are those that can be reimbursed through 1915c waivers or through the Rehab Option. A 2009 report by the Kaiser Family Foundation, *Money Follows the Person: An Early Implementation Snapshot*, available at: <http://www.kff.org/medicaid/upload/7928.pdf>, provides information on the range and types of services covered as alternatives to institutional care.

3. STRATEGIES FOR GETTING PEOPLE WHO ARE CHRONICALLY HOMELESS ENROLLED IN MEDICAID

There are not many ways that chronically homeless individuals can become Medicaid beneficiaries. The obvious one is to have enough of the right kinds of disabilities, for the right length of time, to qualify for SSI, which in turn makes one categorically eligible for Medicaid. But people with serious mental or behavioral health problems often have difficulty enrolling in SSI. Section 3.1 describes efforts to overcome barriers to participation in SSI for people who are chronically homeless.

Alternatively, if a chronically homeless person lives in a state that makes available Medicaid, or a Medicaid-equivalent such as a fully state-paid indigent care program, to people who do not qualify for SSI, he or she may be able to enroll in that program. Section 3.2 discusses current efforts to expand health insurance to people who are chronically homeless who do not qualify for SSI. (Future expansion of Medicaid under the Affordable Care Act is discussed in Section 4.)

3.1. Getting People onto SSI, and Thus Medicaid

PSH projects have a much easier time keeping in the black if their tenants are able to pay part of the rent and if they are eligible for insurance that can reimburse a service provider for much of the care that tenants need. Income from SSI is crucial for many PSH tenants, because without it they would have no income at all. SSI gives them the resources to pay some of the rent, the rest of which is usually covered by a subsidy such as a HCV, project-based Section 8, or a S+C certificate. Becoming an SSI beneficiary is also essential for PSH tenants because it makes them categorically eligible for Medicaid, which can cover much of the health and behavioral health care that tenants need.

In this section we look at three strategies to increase the odds that people who are homeless with serious and complex health and behavioral health needs succeed in becoming SSI and hence Medicaid beneficiaries. First we summarize outcomes and implications from ASPE's evaluation of the Social Security Administration's (SSA's) SSI/SSDI Outreach, Access, and Recovery (SOAR) demonstration projects (Kauff, et al. 2009). Next we describe on-going and expanding work in Los Angeles County to streamline the SSI application process and improve first-time success rates (Boyce, 2010; Burt, 2009). Finally, we review the results of the Frequent Users of Health Services Initiative (FUHSI) in six California counties that recruited uninsured adults who made frequent use of expensive crisis services at county hospitals, many of whom were homeless, and sought to change their behavior (Linkins, Brya, and Chandler, 2008). A key component of their strategy was helping people qualify for SSI.

3.1.1. Results of the SOAR Evaluation

The SOAR Initiative helps individuals who are homeless apply and succeed in qualifying for SSI/Social Security Disability Insurance (SSDI) benefits, with their accompanying eligibility for Medicaid. Approval rates before the SOAR initiative were only an estimated 15 percent for initial applications by people who were homeless, and these decisions took many months to be issued.

SOAR works at two levels. At the systems level, SOAR offers technical and strategic planning assistance to bring social service providers, advocates for the homeless, and state and local public agencies together to modify existing practices. At the direct care level, SOAR trains a few staff in participating states who will then train others--case managers, social workers, and other staff working with people who are homeless--to give them the skills and information needed to help their clients get SSI/SSDI.

States began SOAR participation in waves, with 14 states beginning in wave 1, 11 in wave 2, and 10 in wave 3. An evaluation of the SOAR effort (Kauff et al., 2009) selected six states--three from wave 1 and three from wave 2--for in-depth case studies of the SOAR implementation process. The evaluation collected evidence on the number of SSI/SSDI applications submitted by SOAR participants and their rates of success with those applications. Rates of submissions and successes in the six case study states varied considerably. Of the five case study states for which the evaluators were able to get information on applications submitted and their rates of success, submitted applications ranged from 20 to 187, and rates of success ranged from 26 to 100 percent. Of the remaining 29 states whose SOAR implementation was included in the study, researchers were able to get success rates for 4; these success rates range from 67 to 98 percent, with the number of applications ranging from 55 to 99. The evaluators devoted most of their report to identifying the structural and systems factors that accounted for a good bit of the variations in success rates in the six case study states. They found that states varied widely in how they did SOAR, their commitment to it, and the extent and focus of their activities following the initial in-state planning forums and trainings. The report summarizes these implementation factors in a table that we reproduce here as the simplest way to convey study findings (Kauff et al. 2009, table IV.1, p. 45).

It is easy to see from this table that, as with all new service efforts that require collaboration across multiple government levels, agencies, and people, implementation is key. All of these states “did” SOAR, but they did not do the same SOAR and it would be unfair to SOAR to say that “it” succeeds or fails. Rather, its goals are attained to the extent that its implementers at all levels commit themselves to the work involved in changing their “standard operating procedures,” and follow through on those commitments.

TABLE IV.1. Presence of Factors Facilitating Successful Implementation of SOAR by Degree of Successful Implementation in Case Study States						
Factors	State 1 (Struggled Least to Implement SOAR)	State 2	State 3	State 4	State 5	State 6 (Struggled Most to Implement SOAR)
	Struggled least to implement SOAR → Struggled most to implement SOAR					
Strong and consistent leadership	X	X				
Agency-level support for SOAR	X	X	X	X		
Engagement of SSA and DDS	X	X	X	X		
Structured inter-agency communication	X	X				
Identification of qualified trainers	X	X	X	X	X	
Supervisory support for case managers and/or dedicated benefit specialists	X	X	X	X		
Targeted implementation	X	X				
Outcome data collection	X	X	X	X		

3.1.2. Strategies for Improving the Success of SSI Applications for People who are homeless in Los Angeles County

In California, which supplements federal SSI monthly payments, cash benefits provide \$850/month for an individual, on average. However, most people who are long-term homeless with disabilities are not receiving SSI, nor are they covered by Medi-Cal (California’s Medicaid). Local governments end up paying for their care at public hospitals. Motivation is therefore strong among both health care providers and agencies offering PSH to help as many people as possible to become SSI and Medi-Cal beneficiaries.

The Skid Row Homeless Healthcare Initiative (SRHHI), an effort begun in 2005, identified a Benefits Assistance Project as one of the top priorities during its first year. By the end of 2006, SRHHI agencies had screened 8,400 people for potential eligibility and assisted with 270 SSI applications, of which 193 had been approved.

Since then, county agencies have made major efforts to facilitate successful SSI applications among people who are homeless. Many applications involve extensive interagency cooperation. Los Angeles County participates in the federal SOAR program, and SOAR is one of the factors that have contributed to a recent rise in approval rates in Los Angeles. But Los Angeles has gone way beyond SOAR and made extensive efforts to improve access to medical documentation and the quality of the medical information used in SSI applications.

- Improving access to medical documentation.** One of the major stumbling blocks for SSI applications for people who are homeless is the difficulty in documenting the duration and extent of disabling conditions. People who are homeless usually do not have a “medical home” and seek medical care at the facility most convenient to them at the time they need care. Records are scattered in many facilities, and rarely has the medical professional being asked to complete SSI/SSDI documentation known the person long enough to be able to report that a condition has existed for a long time at a high level of disability.

To overcome this barrier, starting in the early 2000s the Los Angeles County DHS assigned two highly experienced registered nurses to retrieve the needed documentation from the county's many public health care facilities. All DHS hospitals use the same data software, "Affinity," but each hospital has its own computer system and its own system for assigning patient numbers, none of which are linked or integrated across hospitals. The DHS nurses have access to all of these systems, but initially and for several years they had to go to each hospital to search for its patient records. In June 2008, DHS succeeded in getting the nurses access to all of the Affinity systems by establishing seven computers (one for each system) in one central place. This greatly facilitated the process of verifying when and where people got care, and for what. The new structure of data access made it a lot easier for the nurses to get the data for the case managers helping people who are homeless complete their SSI/SSDI applications, thus speeding up the process *and* providing the exact information that shows how long the person has had disabling conditions.

Prior to gaining this access, in the year between July 1, 2007 and June 30, 2008, the nurses received referrals for 122 clients and assisted 82, of whom 51 (62 percent) were approved at first application, 23 (28 percent) were denied and went to appeal, and eight were pending. Statistics for the following year showed the effects of improved data access.

More recently, central data rooms have been established in two more county hospitals as part of extensive countywide efforts to qualify more people who are homeless for SSI. Ten nurses are now working on this effort, which includes a "General Relief (GR) Redesign" at DPSS expected to move more than 10,000 disabled GR recipients from GR onto SSI. Nurses are stationed at DPSS, DHS' county hospitals, and the county jail to facilitate client recruitment and data retrieval to support applications.

- **Improving the medical documentation itself.** DHS has found that SOAR training helps case workers in homeless assistance agencies prepare successful SSI applications. However, even if case workers are able to access medical documentation, hospital records often do not provide the specific information that the SSA needs before it can approve an application.
- The DHS nurses stationed at county hospitals use the data retrieval structure just described to access billing records, which give them service use and diagnosis, along with a few other important facts. But notes in client medical records are not automated. DHS nurses retrieve medical records and make hard copies of essential information, but they are also able to go one step further. Especially for recent treatment, they are able to contact attending physicians, clarify their perception of a patient's condition and needed treatment, and have the physicians enter relevant notes into the case record. This updated record then becomes the documentation sent to SSA. The further advantage of these

practices is that attending physicians gradually become aware of what they need to include in their medical notes, so the hard copy records are slowly improving.

- **Benefits Entitlements Services Team (BEST).** BEST began on July 1, 2009. Commitment of county funds to BEST followed the extensive documentation by then available in the county showing the advantages of helping people who are the sickest and most chronic among those who are homeless obtain SSI (Flaming et al., 2009) and the ability of a well-trained multiagency provider team to develop successful SSI applications. The BEST funding commitment and structure is built on those earlier efforts. During the time an individual is enrolled in the BEST project, an integrated services team works together to document eligibility for disability benefits and coordinate the SSDI/SSI application processes; it also provided direct health and behavioral health care. The team is based at the Center for Community Health, located in Skid Row and run by JWCH Institute, an FQHC offering integrated medical, behavioral health, dental, eye, and clinical pharmacy services that has served the homeless Skid Row population for a long time. The team includes JWCH staff, staff from county public agencies, and non-profit service providers.

The BEST team assists participants in all aspects of the application process, including tracking the clients' whereabouts, providing access to community resources, obtaining identification, providing transportation, and coordinating and managing past health and mental health record retrieval. Local SSA offices and California Disability Determination Services are crucial partners in the BEST project. As of October 8, 2010, 523 participants have been enrolled in BEST; 175 applications have been submitted to SSA and have received a decision. Of the 175, 159 (91 percent) have been approved. As of July 31, 2010, the average length of time from *enrollment in BEST* (not submission of the application) to approval is 52 days.

3.1.3. Frequent Users of Health Services Initiative (FUHSI) in Six California Counties

The FUHSI was a five-year, \$10 million project jointly funded by the California Endowment and the California HealthCare Foundation. Its goal was to promote the development and implementation of innovative, integrated approaches to addressing the comprehensive health and social service needs of frequent users of emergency departments, replacing a costly and avoidable health care utilization pattern with ongoing, coordinated, and multidisciplinary care provided in more appropriate settings. FUHSI funding supported a program office based for six years at the Corporation for Supportive Housing, which in turn awarded planning and implementation grants to counties, supported them with technical assistance, and supervised an outcome evaluation of both the planning and implementation grants (Linkins, Brya, and Chandler, 2008).

Projects had goals for the individuals they served and also had system change goals. Connecting participants to stabilizing services such as housing, health insurance, and income benefits was an important intermediate outcome of the intervention models, and most of the programs were successful in connecting clients to needed resources. Sixty-three percent of program enrollees had no insurance or were underinsured at enrollment. Serving such persons and improving their insurance status was an explicit initial focus of FUHSI. Among these clients, 64 percent were connected to coverage through the county indigent program, and Medi-Cal applications were filed for 25 percent.

Nearly half (45 percent) of the frequent users enrolled in the six programs were homeless at the time of enrollment. Among these, more than a third were connected to permanent housing through HUD HCVs, mainly in the three counties that adopted a service strategy of getting people into PSH.

Some programs were more successful in achieving their systems change goals than others. Four of the six grantees were well on their way to fully sustaining their programs within their area hospitals and counties at the end of the FUHSI funding period. Grantees focused their systems change efforts in the following areas: elevating the awareness and understanding of the needs of frequent users across the county; establishing new collaborations to increase capacity for housing people who are homeless; improving access to mental health and substance abuse treatment; improving communication and care coordination across hospital and primary care providers; streamlining processes for securing SSI benefits, food stamps, and Medi-Cal coverage; and developing a sense of “collective accountability” within the community for the frequent user population. This has led to cross-system approaches to addressing a variety of issues beyond “frequent ED use,” such as discharge planning, respite care, pain management, and overall improvements in case management.

Counties in which hospital administrators were committed to FUHSI efforts achieved greater successes than those where this commitment was lacking. Achieving success with frequent users requires significant financial investment, intensive health and behavioral health interventions, small caseload sizes, resources and capacity in the community, partnership across systems of care, and an understanding that the issues faced by the frequent user population are complex. Treatment solutions will require long-term vision and commitment.

3.2. Helping People without SSI to Enroll in Medicaid

Until enactment of the Affordable Care Act, Medicaid eligibility for childless adults was generally limited to those who receive SSI. Because the SSI definition specifically excludes disabilities attributable to substance abuse, many persons who are chronically homeless have not qualified for SSI and as a result have been unable to enroll in Medicaid.

States could, however, expand eligibility to people who do not meet Medicaid's "categorical" eligibility requirements using state funds (without matching federal funding) or through the Section 1915c Medicaid waivers discussed in Section 2.3.4. Medicaid waivers permit states to expand coverage to childless adults not receiving SSI. States may put ceilings on enrollment and provide a more limited benefit package than offered by regular Medicaid. These waivers require cost sharing by the state.

In 2009, five states (Arizona, Indiana, Maine, Minnesota and New York) were providing coverage for childless adults that was comparable to Medicaid, and 15 states offered coverage that was more limited than Medicaid (Somers et al., 2010). Some states had closed these programs to new enrollment as of 2009. The State of Maine provides an example of a successful approach to expanding Medicaid enrollment in a relatively poor and mostly rural state that has nevertheless been committed to providing needed health, behavioral health, and support services to chronically people who are homeless with disabilities.

3.2.1. Maine's "Non-Categorical" Medicaid Program

For at least the past 10 years, MaineHealth, the state's Medicaid program, has accepted very low income childless adults who do not fit into a usual Medicaid categorical eligibility group. People who are homeless with disabilities (but who are not SSI receipts) comprise a significant proportion of these "non-cats," as this group of people is known. The cost of care for non-cats is borne by both state government and Federal Government under an 1115 waiver, at the state's usual match rate, but a smaller array of services is covered than is true for categorically eligible households. When eligibility for non-cats opened, the state had resources to support 10,000 beneficiaries; it was quickly overwhelmed when 16,000 people qualified. Since that time the state has opened and closed the rolls to keep them close to 10,000.

Most of the CMHCs in the state are Medicaid providers. These CMHCs have participated in developing most of Maine's PSH, usually with housing developer partners. One non-profit housing developer, which created and now operates about 20 percent of the PSH in the state outside of Portland, partners with different CMHCs, depending on the location of the housing.

Various sections of the state Medicaid Plan are used to support tenants in PSH. Coverage opportunities were worked out among providers and state agency staff, including state Medicaid office staff. Applicable provisions include:

- Section 17 covers community integration services and is available to those in need who are eligible for Medicaid. Care supported by this section includes regular case management, intensive case management (working largely with people being discharged from institutions), ACT, daily living supports, and day care. CMHCs are the most likely to provide the care covered by this section.

- Section 65 covers outpatient health and behavioral health treatment and medications management. CMHCs bill under this section, as do primary health care providers.
- Section 13 covers only referral and linking activities. Medicaid pays for activities under this section performed by staff of homeless emergency shelters in their work of helping residents get rent subsidies, find apartments, get settled, and get linked to benefits. Once settled, clients are transferred to a case manager covered under Section 17. Shelter staff members were trained to do this work and become certified to provide Medicaid-covered services as Mental Health Rehabilitation Technicians, who operate under the supervision of certified medical and/or behavioral health staff who also work for the shelters. Shelter staff helping clients use MaineHousing's Bridge Rental Assistance Program and S+C to obtain housing have taken advantage of Section 13 to cover housing location, negotiations, and settling in. These are face-to-face contacts and thus billable.

During recent years, disability rights advocates from Maine Equal Justice and the Disability Rights Center have made a tremendous effort to help people already in the "non-cat" component of MaineCare to qualify for SSI. They have succeeded with fully two-thirds of those who were non-cats three years ago. This is typically accomplished using an alternative diagnosis, either psychiatric or other medical condition. The advocates mounted statewide case worker trainings and worked with SSA and state agencies to complete applications appropriately and facilitate their processing--all without being a state that participated in SOAR training, although two small pilot SOAR projects are about to start. The 6,700 or so non-cat slots thus opened up have been filled with others who will go through the same process of applying for SSI.

4. HEALTH CARE REFORM AND SERVICES IN PERMANENT SUPPORTIVE HOUSING

The Affordable Care Act of 2010 has the potential for greatly expanding the use of Medicaid-funded services in PSH and for people who are chronically homeless. However, much depends on the implementation, including federal regulations and the decisions that will be made by state governments. The most important provisions of the Affordable Care Act for supportive housing for people who are homeless are:

- Expanded Medicaid eligibility for homeless individuals who are not participating in SSI;
- The selection of benefit levels and packages for the newly eligible population;
- Expanded use of medical homes or health homes;
- Greater integration of primary care and behavioral health care;
- Expanded funding for FQHCs;
- Increased community-based long-term care.

4.1. Expanded Eligibility

The Affordable Care Act of 2010 significantly expands Medicaid eligibility beginning in 2014 for people with incomes below 133 percent of the FPL. This includes nearly all of the childless adults, who are homeless and not currently eligible, as well as many parents and other adults. The Act permits states to elect to “phase in” coverage for the newly eligible group of people at any time after April 2010. States that adopt this new coverage option will receive federal matching payments at their regular federal medical assistance percentage until January 2014, when a higher federal matching rate will be provided (initially 100 percent).⁷ Connecticut and the District of Columbia are already using this new option to cover childless adults, and several additional states are considering it.

4.2. Costs and Benefit Levels

States will have many decisions to make about enrollment procedures, benefits packages, and health care delivery systems within guidelines provided by the Federal Government. While there is some evidence that many newly eligible Medicaid beneficiaries, particularly working adults with incomes close to 133 percent of the FPL, will be healthier than current Medicaid beneficiaries (Holahan, Kenney, and Pelletier, 2010), the lowest income subset of the Medicaid expansion--those with incomes below 50 percent of FPL, is likely to include people with the most complex health and

⁷ See CMS State Medicaid Director Letter #10-005.

behavioral health problems that are associated with long-term unemployment. Furthermore, those with the most acute or complex needs are likely to enroll first, in part because providers who currently serve them will make sure they get enrolled so that the providers can get reimbursed for care delivered in hospitals, emergency rooms, clinics, and other settings that is currently uncompensated (and paid for by state and local taxes). For this subset of people who are newly eligible for Medicaid, costs of health care and service needs are likely to be closer to those of disabled people who are currently eligible for Medicaid, instead of comparable to relatively healthy parents enrolled in Medicaid or individuals enrolled in employer-based health coverage.

Federal law does not require that newly eligible Medicaid beneficiaries receive the standard Medicaid benefit package that might include coverage for some of these services. For people enrolled in the new eligibility group, states must provide a package of benefits that is equivalent to “benchmark” coverage, which may be more limited than standard Medicaid benefits. As anticipated in the Affordable Care Act, benchmark benefits will be set by state health insurance exchanges, with the benefit design pegged to the Federal Employees Health Benefit Plan or the largest commercial health plan in a given state. Benchmark benefits may not meet the needs of those newly eligible Medicaid beneficiaries who have long histories of unemployment, homelessness, chronic health and disabling conditions. Benchmark benefits are likely to cover a limited range of services that are provided in hospitals, clinics, or other outpatient health and behavioral health care settings. PSH service models that incorporate engagement and care coordination strategies and integrate health care with services to address needs related to housing, employment, and interactions with the criminal justice system likely will not be covered under benchmark benefits. Federal and state policy makers may decide to exempt some newly eligible Medicaid beneficiaries from coverage under benchmark benefit packages and instead to provide the standard Medicaid benefit package.

4.3. Medical Homes or Health Homes

Patient centered medical homes or health homes have been recognized as a model for effectively delivering care for persons with chronic health and/or behavioral conditions. The Affordable Care Act contains provisions (Section 2703) that authorize a state option for Medicaid beneficiaries with chronic conditions, including SMI or substance abuse disorders, to select a health home, building on the experience of Medicaid’s current Medical Home demonstration programs. During the first eight quarters of operation, the Federal Government will provide a 90 percent match rate to states that implement health homes. Federal guidelines have just been released for this pilot, and the National Committee for Quality Assurance has developed standards for medical homes that include the use of patient self-management support, care management, evidence-based guidelines for chronic conditions, and performance management and improvement. Core attributes of patient centered medical homes include comprehensive whole-person care, improved and timelier access to care, and coordination across all elements of the complex health care system and the patient’s

community. Leaders in the field of behavioral health have highlighted the quality and cost benefits of multidisciplinary care that integrates attention to medical, mental health and substance use conditions, with services that focus on wellness and recovery (Mauer, 2010).

Care coordination or care management strategies (which may be incorporated into a medical home model or implemented separately) focus on the small number of Medicaid beneficiaries whose care is associated with a very large percentage of Medicaid spending.⁸ Effective models target high-risk patients, incorporate both medical and social supports, and provide in-person contact between patients and care coordinators (Berenson and Howell, 2009). Services focus on assessing, care planning, educating, monitoring, and coaching patients on self-management. Staffing often relies on nurse coordinators, but also involves social workers, and care coordinators interact with primary care providers.

PSH service providers vary widely in the extent to which their service delivery models and practices are aligned with the statutory provisions (and guidance that will be issued by the Federal Government) for medical homes and care coordination. Some PSH service providers are implementing comprehensive service models that are likely to incorporate many, if not all, of the features of medical homes. If they are not implementing them now, they may have the capacity to do so.

The chronic homelessness voucher demonstration could provide opportunities to examine issues related to targeting of PSH to persons with multiple chronic conditions who are likely to need or be served by medical homes or care coordination services. The demonstration could examine the extent to which PSH service providers may have the capacity to qualify as health homes or to partner with qualified health homes to achieve required performance standards and outcome measures.

4.4. Integration of Primary Care and Behavioral Health Care

Among persons with SMI, high rates of chronic health conditions often result in high levels of health care expenditures and premature mortality (Mauer, 2009). Psychiatric illness is prevalent among the highest-cost Medicaid beneficiaries with chronic health conditions, many of whom have multiple chronic conditions. The most frequent users of care in hospital emergency rooms have very high rates of mental health and substance abuse problems.⁹

⁸ Fewer than 4 percent of Medicaid beneficiaries account for nearly 50 percent of costs. The majority of these are disabled adults who are eligible for Medicaid because they receive SSI, often with multiple physical, behavioral, and social needs, who lack access to coordinated care (Bella et al., 2008; Kronick, Bella, and Gilmer, 2009).

⁹ See <http://www.dshs.wa.gov/pdf/ms/rda/research/11/119.pdf> for analysis by Mancuso et al. that examined emergency room utilization by Washington State's aged, blind, and disabled Medicaid beneficiaries. Also see Linkins, Brya, and Chandler (2008).

Current systems for financing and delivering physical health care to address medical conditions and behavioral health care to address mental health and substance abuse problems are fragmented. Often separate networks of providers of medical, mental health and substance abuse services have limited communication to facilitate care coordination on behalf of shared clients. Furthermore, reimbursement mechanisms may create barriers or disincentives to deliver care for medical and behavioral health conditions at the same location on the same day. “Carve-outs” of Medicaid benefits for behavioral health care may assign financial responsibility for the non-federal share of Medicaid expenditures to different levels of government (state or county), failing to align fiscal incentives for investments in behavioral health services that produce savings by reducing avoidable hospitalizations for medical conditions (Raven et al., 2010). In many states coverage for substance abuse treatment services under Medicaid is very limited.

Legal requirements in the Affordable Care Act for parity between mental health and addiction services and medical/health services will expand opportunities for reimbursing behavioral health services provided in primary care settings, where many low income people and members of ethnic minority populations are more likely to obtain care than in the specialty mental health system. The largest change will come in coverage for treatment of substance use conditions.

In some cases, service models that have been implemented in conjunction with PSH already are delivering services that focus on wellness and reducing health risks and integrate care for medical and behavioral health conditions. Collaborative partnerships or integrated models use multidisciplinary teams that include primary care providers, nurse care managers, and mental health and substance abuse counselors. New funding for FQHCs (described below) and expanded funding for SAMHSA grants provided through the Primary and Behavioral Health Care Integration Program may provide greater opportunities to sustain or expand the delivery of integrated primary care and behavioral health services for PSH residents.

4.5. Expanded Funding for Federally Qualified Health Centers (FQHCs)

CHCs and HCH programs will play a significant role in expanding the nation’s capacity to delivery health care services to millions of Americans who will gain coverage through the implementation of health reform. The Affordable Care Act provides \$9.5 billion in services funding increases for Health Center Program grants, which are allocated by HRSA, to establish new health center sites and to expand the capacity of existing health centers to deliver more primary care medical services to underserved areas or populations, including recuperative care services (medical respite) and other health services such as behavioral health, oral health, vision, pharmacy, or “enabling services.”¹⁰ Enabling services can include case management, eligibility assistance,

¹⁰ See Health Center Expanded Services funding announcement HRSA-11-148 CDFR#93.527. In addition \$1.5 billion will be provided to support major construction and renovation projects at health centers.

outreach, housing assistance, employment and education counseling, food bank/meals, and other types of services.

While there will be many competing demands for CHC expansion funding, these resources may be used in some communities to create or expand CHC services for resident of PSH, as well as outreach and eligibility assistance to help link people who are chronically homeless to Medicaid benefits and housing assistance.

4.6. Home and Community-Based Alternatives to Institutional Care

The Affordable Care Act contains a number of provisions that are designed to increase community-based long-term care options and provide alternatives to institutional or care in nursing homes or other restrictive settings. These provisions will incentivize and support state efforts to “re-balance” spending on long-term care in community and institutional settings and constrain the growth of Medicaid spending on nursing home care. In a few states, these efforts are being aligned with strategies for ending chronic homelessness, leading toward unified strategies for linking affordable housing investments for very low income people with disabilities to Medicaid-financed services that help people with physical or mental disabilities live in community settings (see, e.g., Technical Assistance Collaborative, 2009). There are several reasons for states to develop unified strategies for creating and financing PSH for persons who are experiencing or at risk of homelessness and/or unnecessary institutionalization, including growing evidence of nursing home utilization and costs among chronically homeless adults who are getting older and more likely to have disabling health conditions.

There may be opportunities for states to develop a more consistent strategy for financing services in PSH and a more coordinated and consistent policy framework regarding housing and services for people with disabilities and high levels of vulnerability who need affordable homes and long-term support. Section 2402(b) changes rules for 1915(i) waivers, permitting states to cover HCBS under a Medicaid state plan option. The HCBS Option offers states a clearer path to covering statewide a comprehensive array of services and supports for persons who are chronically homeless and disabled by SMI, avoiding not only the burden of applying for a waiver, but also eliminating the requirement to prove cost neutrality. While services could be targeted to specific need groups, waiving comparability, states will not be permitted to limit the number of eligible individuals in the target group, establish wait lists, or restrict use to limited parts of the state.

5. SUMMARY AND IMPLICATIONS

Research indicates that supportive housing works to end the condition of homelessness for individuals with high health and rehabilitation needs when a range of services are available to support people and stabilize their living situations. Evidence on cost offsets and potential savings is more developed and certainly more widely reported than evidence of the impacts of PSH on tenant outcomes. When examining cost offset studies, it is always important to note two things--which agencies and their costs are included in the analysis, and what types of homeless people are being housed and supported. For reports of PSH tenant outcomes, it is important to note how different studies measure specific dimensions of outcomes--little consistency exists across studies.

Cost studies that gather data on averted service use and related costs from a wider range of agencies and services are more likely to show large cost offsets and even potential savings than those whose focus is narrower. Likewise, cost studies that focus on change of service use among “frequent users” will show larger cost offsets than studies that examine a broader homeless population, even among people who are chronically homeless. There are also “fine points” of cost studies that are rarely reported but may affect a study’s conclusions--chief among these is how researchers arrive at the “unit cost” they use to calculate offsets and savings. It is not easy to be sure that one is comparing “apples to apples” when one tries to summarize the results of cost offset analyses.

“Apples to apples” comparisons are even more elusive when examining reports of PSH tenant outcomes, due to great inconsistency in approaches to measurement. In general, one may place more faith in reports of improvements on outcome dimensions measured concretely as opposed to those measured in terms of perceptions or satisfaction (for measuring continued drug use, clean urines or reductions in number of days of any use rather than reports of “seems to be using less,” or “I’m doing better on controlling my drug use,” and for work, evidence of employment and earned income rather than “satisfaction with work”).

To succeed with its target population of persons who are chronically homeless, the HHS/HUD PSH voucher demonstration will need to cover: housing stabilization services; integrated primary care and behavioral health services; and rehabilitative and recovery support services. Because of historical barriers to Medicaid eligibility for many individuals who meet the federal definition of chronic homelessness, their health status has been neglected and they are likely to have significant pent up needs for care.

The Affordable Care Act provisions to expand eligibility for Medicaid will significantly increase the number of people who are chronically homeless and PSH tenants who have Medicaid benefits. This will improve access to the Medicaid-covered services that this target population needs to succeed in PSH, including services to address mental health and substance abuse problems, while also providing greater

opportunities for Medicaid providers to obtain reimbursement for delivering health services linked to PSH sites or housing assistance programs.

The Health Homes provision of the Affordable Care Act provides new opportunities for Medicaid to cover the expense of care coordination and the integration of medical and behavioral health services, and to use funding mechanisms to pay for team-based models of care that achieve demonstrated savings and better outcomes. Person centered medical homes will be a key approach to coordinating care for populations with complex needs for health care, human services, and long-term services and support, including persons who are chronically homeless, many of whom will be newly eligible for Medicaid coverage. For the target population of persons who are not only chronically homeless, but also have multiple chronic medical and behavioral health conditions, the option for enrollment in a health home providing timely and coordinated access to all elements of the complex health care system holds significant promise of improved quality and cost benefits.

Other Affordable Care Act provisions hold promise for expanding and better integrating coverage and care for individuals who are chronically homeless and currently eligible for Medicaid due to the disabling effects of SMI. The HCBS Option permits states to elect coverage of a broad array of recovery oriented treatment and community support services for persons with SMI, while avoiding the burden of filing a waiver application and eliminating the requirement to prove cost neutrality. Some states will be able to use this approach to transform the systems of financing and delivering supportive services linked to housing assistance, to provide a range of housing options for people who might otherwise be chronically homeless and/or living in nursing homes. As a growing number of chronically homeless people are older adults with serious medical problems in addition to mental illness, and some are increasingly frail and vulnerable, there will be increasing opportunities for PSH to provide an alternative to nursing home care, and to use HCBS financing mechanisms.

Under current funding conditions, assembling the array of services they need and assuring that health care providers and housing staff work together to support PSH tenants is often a challenge. There are also related gaps in the sufficiency of provider capacity and state and local government match for expanded Medicaid services. Given these conditions, the shift of these individuals from a state of chronic homelessness to a state of housing stability may pay off in terms of reduced use on their part of crisis/emergency services as well as improvements in their health and well-being. However, while PSH tenants' move to more appropriate care may reduce the costs they themselves impose on the homeless, crisis, or criminal justice systems, cost savings may not be realized because of other unmet demands in those systems. Also, when treating long neglected health conditions, cost mitigation and clinical improvements may be slow to emerge, suggesting careful consideration of how and when to measure outcomes as well as what performance based reimbursement and financing methods to apply to the PSH voucher demonstration. The literature is clear that the greatest savings will accrue by targeting the most frequent and highest cost users of care. In addition to cost considerations, the demonstration offers the opportunity to assess the

particular mix of services that are most effective for each subgroup within the population of persons meeting the federal definition of chronic homelessness. To determine not only the impact of stable housing on outcomes but also the nature of clinical outcomes, the literature suggests that the evaluation should employ standard measures and consistent methods.

5.1. Knowledge Gaps Remaining

For all the information that has been assembled for this Literature Synthesis and Preliminary Environmental Scan, there is still much to learn about how PSH housing and service providers are able to fund their work. Expanding knowledge in these areas will be a major goal of the site visits and supplemental phone conversations that are the next step in the Environmental Scan. Areas of particular interest during site visits will be:

- What Medicaid provisions are being used to cover the various services needed by PSH tenants who were chronically homeless? What are the gaps/what is not covered that is needed?
- What is the thinking about revisions to state Medicaid plans to be ready for 2014? Are steps being taken to make it easier to cover services needed by PSH tenants, or might things get even more complicated or tighter than they are at present?
- How are state and local budget constraints having an effect on the use of Medicaid to reimburse services provided to supportive housing tenants?
- Physical health care--what happens when the primary client serving agency is in the mental health system? It can cover many of its own behavioral health services under Medicaid, but how does it assure that its clients receive the physical health care they need, if they do, and how is health care integrated with other care, if it is?
- Treatment for substance use conditions--is Medicaid being used to cover services that focus on substance use problems, including services that focus on engagement and increasing motivation to pursue active treatment as well as relapse prevention? If so, how (this has been very difficult to do in many communities)? If not, how are treatment and recovery support services being provided to PSH tenants? Are substance abuse treatment agencies being approached/included in integrated teams?
- Is there a relationship between Medicaid-reimbursed services and access to supportive housing? When services in PSH are funded through coverage for mental health benefits, is PSH available to people who are chronically homeless without SMI but with serious medical conditions and/or substance use problems?

- Aligning services that may be reimbursed under different financing mechanisms (FQHC + rehab option, etc.).
- Financing for multidisciplinary teams--what costs and services are covered? How is care coordination covered? How do providers cover the costs of engaging clients in care and developing trust?
- Information sharing in multiagency collaborations to link housing and services (privacy, Health Insurance Portability and Accountability Act)--how are these issues handled?
- Service provider experiences with PHAs--what have experienced service providers learned about working with PHAs to get their homeless clients through the application processes for S+C, Section 8, and/or project-based rental assistance? Are there service providers with no experience working with PHAs who will be facing the task of helping a lot more people who are homeless obtain rental assistance controlled by PHAs? How can their pathways with PHAs be smoothed?
- How much are services and benefits in these communities still siloed, even when there are some exemplary integrated treatment/support structures?
- What happens at the local and state levels that helps bring it all together, facilitates communication until people learn to work together, and keeps it together and growing? What's the "glue," and how is it supported?

5.2. Abiding Realities of New Practices and Demonstration Programs

Whatever the study team for this project learns from its Environmental Scan, among its findings will be a reflection on "lessons learned" by those embarking on new practices, with the hope and expectation that conveying these lessons in a final report will make it easier for others to avoid some of the pitfalls and overcome some of the challenges. For decades, studies of service delivery mechanisms and demonstration programs have discussed "lessons learned" as one of their most important report sections. Reviewing these sections leads a reader strongly to the conclusion that we have been "learning" the same lessons over and over. Studies of services and systems integration efforts from the 1970s articulate many of the same lessons as studies from the 1980s, 1990s, and now the 2000s. They are remarkably easy to summarize:

- It always takes longer than you think it will. However long you think it will take to get an approach up and running, double it. If new relationships among two or more agencies are involved, triple it, especially if they have never worked together before on anything.

- Clients have multiple and complexly interacting issues; funding and eligibility silos impede the ability of service agencies to help their clients. Break down the silos.
- People and agencies that have coordinated with each other in the past are likely to be the most successful at developing additional coordinative mechanisms or moving toward more intensive service integration.
- No single structure will work in every community. Each community has to evolve its structure for itself, paying attention to the location of talent, interest, leadership, and resources. Trying to impose a particular structure from without is more likely to slow things down than speed them up.
- Integrated services are good for clients with complex needs--they are more likely to get what they need, in a timely manner, and with due regard for all the issues they are trying to handle. But they may not be necessary for all clients. The motivation of any community to develop integrated service mechanisms or to integrate systems will depend on the scope of the problem being addressed and the resources available to address it.
- Having a way to track progress, get feedback, use data to see how you are doing, can help the program development process along in many important ways.
- Having a coordinator, or some person whose job it is to keep things moving, helps. If carefully tended, a successful effort at service and systems integration has a tendency to widen in scope and have payoffs for the community beyond the original goals. Many of the examples described earlier in this paper have a history of this type of development over time.

So, why do Congress, other policy makers, managers, and practitioners seem not to have taken the lessons of the past decades to heart? Why do we appear to need to learn the same lessons repeatedly, without starting at least a step or two ahead of the game the next time we try to create structures to serve people or households with complex needs?

Some part of the answer to this problem of starting each time from zero lies with the array of challenges that the same evaluation reports also describe. As with the lessons learned, the challenges also are similar across the decades, suggesting that even when they are met and surmounted in specific instances, they have a tendency to relapse to the “status quo ante” of rigid silos unless some very strong steps are taken to keep things open and moving forward. Challenges identified frequently across four decades of program and policy evaluation reports include:

- “Turf” issues--agencies want to keep control of the services and clients they have traditionally served and are not always eager to share clients or yield control as would be necessary in an integrated service approach.
- Agency “cultures”--different agencies are staffed by people with different training, coming from different disciplines, and tending to see the world (and clients’ problems) in specific ways. They also are subject to the rules and regulations that go with their specialty, and are usually ignorant of the rules and regulations governing other agencies. People who perform cross-agency work have to learn each other’s languages and come to appreciate each other’s strengths and constraints.
- Data privacy constraints--all kinds of rules and laws govern who can share what information with whom, and under what conditions. With good will all around these constraints can usually be overcome to the benefit of clients, but it takes time. When an agency does not really want to work collaboratively, data sharing issues can be used to resist full integration.
- Inadequate resources--agencies do not have enough resources to do the work they already have, and do not want to take the time to develop new ways of doing things or to focus on the hardest to serve among their clients or eligible population.
- The population to be served is not big enough, popular enough, or considered “worthy” enough, to warrant the effort that coordination or collaboration takes.
- And of course, silos.

What one *can* see across the decades is that lessons *are* learned locally, and challenges once overcome *locally* tend not to recur, or at least not to be as difficult to handle the next time they arise. Studies often list as one of the factors facilitating good interagency outcomes through collaboration the fact that “the agencies already had a good working relationship.” Locally, agencies with good relationships are able to capitalize on earlier investments in getting to know each other and working out feasible and useful cross-agency interactions. The problem for policy makers is: how can *most* places in the country move beyond silos when that is necessary?

Evaluations of changes arising from TANF provide some of the answer--(1) set general program requirements and standards, then give states and localities flexibility to decide how they will fulfill those requirements; (2) give them enough resources to make it worthwhile for different agencies to come to the table; and (3) focus on a population big enough, and of enough concern locally, to pull in the various agencies that comprise the safety net.

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