



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

HEALTH, HOUSING, AND SERVICE SUPPORTS FOR THREE GROUPS OF PEOPLE EXPERIENCING CHRONIC HOMELESSNESS

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Office of the Assistant Secretary for Planning and Evaluation

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PREFACE TO THE ISSUE PAPERS

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

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

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

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

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

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

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

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

- **Paper 1**--describes three subgroups of the people experiencing chronic homelessness, and the services and housing configurations currently supporting them. *Health, Housing, and Service Supports for Three Groups of People Experiencing Chronic Homelessness*. Cambridge, MA: Abt Associates Inc., 2012. M.R. Burt & C. Wilkins.
- **Paper 2**--describes the ways that Medicaid is being used now and might be used in the future under provisions of the ACA to serve chronically homeless people. *Medicaid Financing for Services in Supportive Housing for Chronically Homeless People: Current Practices and Opportunities*. Cambridge, MA: Abt Associates Inc., 2012. C. Wilkins, M.R. Burt, & D. Mauch.
[\[http://aspe.hhs.gov/daltcp/reports/2012/ChrHomIs2.shtml\]](http://aspe.hhs.gov/daltcp/reports/2012/ChrHomIs2.shtml)
- **Paper 3**--describes innovative approaches to establishing Supplemental Security Income (SSI) eligibility. *Establishing Eligibility for SSI for Chronically Homeless*

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

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

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

Second Phase: Case Studies of New Strategies

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

HIGHLIGHTS

In 2014, nearly all chronically homeless people who are currently uninsured will become eligible for Medicaid, along with millions of other poor people. Homeless people with complex health and behavioral health conditions need a wide range of health and other services and supports if they are to get and keep housing, pursue recovery, manage chronic health conditions, and stay out of hospitals. ASPE wanted to learn about how the nation's most innovative providers currently use Medicaid and other federal resources to provide needed care.

Using the Knowledge Gained to Guide Policy

The Federal Government has a goal of ending homelessness for all chronically homeless people by 2015. A key strategy to reach that goal is PSH, which offers formerly homeless people with disabilities a permanent home along with the health care and other supportive services needed to keep it. Medicaid is one of the sources of funding currently used to cover the costs of the service element of PSH. Knowing the issues arising from current uses of Medicaid for this population can help guide Medicaid policy development under the ACA toward structures that assure appropriate care for formerly homeless disabled occupants of PSH.

What Medicaid Does Now for Chronically Homeless People

At best, only about 1 in 4 homeless people living on the streets are currently enrolled in Medicaid, despite being extremely poor and usually in very bad health. For homeless people with disabilities who have been lucky enough to move into PSH, Medicaid is one of the three biggest funding sources for the health and supportive services that help them regain health and keep housing.

Not All Chronically Homeless People Have Equal Access to Medicaid

Chronically homeless people's health conditions and the likelihood that they currently receive the services they need are heavily interrelated. Certain conditions require different types of care than others, and those same conditions make it more or less likely that Medicaid will be available to help cover the service costs. The chronically homeless population can be divided into three groups, differentiated by two factors-- having a serious mental illness (SMI) that would meet the medical necessity criteria for receiving specialized mental health services, and being enrolled in Medicaid. Both factors have implications for access to care, and especially for what types of agencies are most likely to serve group members. The three groups of chronically homeless persons are:

- **Group 1:** Persons who are *not* enrolled in Medicaid *and do not* have a qualifying mental illness.¹
- **Group 2:** Persons who *are* enrolled in Medicaid *but do not* have a qualifying mental illness. This group includes people who may have severe physical health conditions as well as trauma-related emotional conditions, substance use disorders, and/or types of mental health disorders that do not meet medical necessity criteria for specialized services.
- **Group 3:** Persons who *are* enrolled in Medicaid *and do* have a SMI that meets medical necessity criteria for specialized services. People in this group may also have co-occurring health or substance use conditions.

Different Agencies Serve the Different Groups

Housing and supportive services for people in Groups 1 and 2 are most likely to be provided by agencies in a community's homeless assistance network, including PSH providers funded through the U.S. Department of Housing and Urban Development, health providers such as Health Care for the Homeless and CHCs that receive some funding from HHS's Health Resources and Services Administration, and public crisis/emergency services such as hospital emergency departments. The people in Group 3 are the most likely to be served by public and non-profit mental health service agencies.

Differential Likelihood of Receiving Permanent Supportive Housing

The greatest array of funding sources are available for people in Group 3, and they are thus the most likely to become tenants of PSH and to receive the most comprehensive array of health care and supportive services while there. In addition to Medicaid, mental health-specific funding comes from contracts through state and local public mental health agencies and federal resources through HHS's Substance Abuse and Mental Health Services Administration.

Challenges in Using Medicaid as a Way of Funding Supportive Services in Permanent Supportive Housing for Chronically Homeless People with Disabilities

Providers face many challenges as they try to obtain through Medicaid a significant proportion of the resources they use to deliver health care, case management, and behavioral health services to support tenants in PSH. Among these challenges are:

¹ Some homeless persons with a qualifying mental illness may not be enrolled in Medicaid but they are likely to be eligible for Medicaid enrollment. Providers of services in PSH can usually assist these people to establish eligibility for Medicaid benefits, so our description of these three groups assumes that these people will be included in Group 3.

- Establishing Medicaid eligibility for clients likely to qualify, following procedures, assembling the required documentation.
- Qualifying as a Medicaid provider.
- Covering the often-extensive time commitments needed to engage and serve the target population.
- Covering the time it takes to coordinate care and services across primary care, mental health care, substance abuse treatment, and housing needs, often provided by different agencies.
- Coordinating care for people with multiple issues when different funding streams for different types of Medicaid-covered benefits have different eligibility criteria, different facility requirements, different billing and reporting schedules, different definitions of medical necessity, and other divergent practices.
- Dealing with restrictions on visits per day, location of care (e.g., within clinic walls or in people's homes), credentialing (e.g., who can deliver Medicaid-reimbursed services), and similar issues.

Despite these challenges, health and behavioral health care providers in many communities are working to deliver quality care and support services that help chronically homeless people end their homelessness and take steps toward recovery and stability in housing, seeing this approach as a cost-effective alternative to the revolving door of streets, shelters, hospitals, detox facilities and jails. Increasingly many of these providers are relying on Medicaid reimbursement to cover a portion of the costs of the services they deliver, and looking for ways to provide more integrated and effective care to all of the chronically homeless people who need PSH.

1. INTRODUCTION

People with complex physical and behavioral health conditions are at high risk of losing housing. Once homeless, many make frequent and often avoidable use of emergency rooms and inpatient hospitalization. Their health conditions can usually only be ameliorated if they have a safe, stable, and secure living environment, but their homelessness often exacerbates health difficulties, making it increasingly unlikely that people can get back into housing on their own. Extensive evidence accumulating over the past decade shows that housing homeless people who have significant, co-occurring health and behavioral health needs makes engagement in cost-effective care possible. In turn, housing coupled with appropriate care and supportive services reduces health risks, restores functioning, and facilitates recovery. This package of housing plus supportive services is known as permanent supportive housing (PSH).² PSH also helps people avoid actions and decisions that would cause them to lose their housing again and return to the inappropriate and expensive use of crisis health services (Burt, Wilkins, and Mauch, 2012; Caton, Wilkins, and Anderson, 2007).

Research reveals the value of PSH, but also indicates that the nature of its supportive services component varies considerably. Variation often depends on tenant characteristics and funding sources, which themselves are intricately linked. This paper describes the differential access to services and supports for three groups of chronically homeless people who already live in PSH or would benefit from doing so. Its goal is to identify what the differences are across groups, why they exist, and where Medicaid comes into the picture. To help readers less familiar with the idea of PSH understand this discussion better, this introduction provides a brief description of the housing and service components of PSH.

1.1. Housing Configurations

The housing component of PSH is almost always structured in one of three ways:

- As projects or buildings in which all units are PSH (dedicated building or site-based model).
- As apartments scattered around the community in private rental housing (scattered-site model).

² PSH is a phenomenon of the 1990s and 2000s, when homeless assistance systems evolved and their goals shifted and changed. PSH beds available to end people's homelessness went from about zero in the late 1980s to estimates of 114,000 beds in 1996 (Burt et al., 1999), 177,000 beds in 2006, and 236,000 beds in 2010 (DHUD 2011, chapter 5). The number of PSH beds added to the stock for the 10 years between 1996 and 2006 was about 6,300 beds a year, while for the 5 years between 2006 and 2010 almost 12,000 beds were added annually. The increased production reflects the push by many communities since the mid-2000s to use PSH to end homelessness, and especially to end it for those who have been homeless the longest.

- As buildings in which PSH tenants occupy some, but usually fewer than half, of units in affordable housing projects, with low and moderate-income tenants occupying the remaining units (a mixed-use or integrated model).

The housing component of PSH virtually always relies on:

- **Rent subsidies** that make it possible for very poor formerly homeless people to afford housing. These mostly come from U.S. Department of Housing and Urban Development (HUD) programs (mostly Supportive Housing Program (SHP), Shelter Plus Care, Housing Opportunities for People with AIDS, and Housing Choice Vouchers (HCVs)), subsidies from the HUD-Veterans Affairs Supportive Housing (VASH) program jointly administered by HUD and the U.S. Department of Veteran Affairs, and state or local government subsidies.
- **Tenant contributions** to rent, most commonly set at 30 percent of tenant income.
- **Additional operating revenues** from HUD programs, state and local service agencies, and private fundraising.

1.2. Supportive Service Components

Supportive services are required during all phases of the person's engagement with PSH. The types of services vary, and are described below.

1.2.1. *From First Contact to Moving Into Permanent Supportive Housing*

The supportive services that bring people into PSH have three elements that are conceptually distinct but often happen concurrently in practice:

- **Outreach and client identification**--walking the streets and checking at drop-in or resource centers, hospital emergency rooms, jails, soup kitchens, sobering centers, shelters, and other locations frequented by homeless people. This first step is essential and is done largely beyond office walls, because that is where the people will be found.
- **Engagement**--interactions over days or months to establish a trusting relationship and start linking people to treatment, services, and benefits. During this time, health professionals and other outreach staff help people apply for food stamps, get treatment for obvious health problems (e.g., skin diseases), start the application process for Supplemental Security Income (SSI), and establish Medicaid eligibility in states where that is a process independent of being an SSI beneficiary.

- **Finding housing**--helping homeless people apply for subsidies, identify units, work with landlords, move into housing, and acquire household goods. This work may be done by outreach staff, regular case managers, or specialized housing/landlord liaison personnel. In “housing first” approaches it begins immediately after first contact. It is often facilitated by: arrangements with local housing agencies that administer rent subsidy programs; well-cultivated and longstanding relationships with a pool of cooperative landlords; or registries of affordable housing developments.

1.2.2. Stabilizing People in Housing

Once programs succeed in getting people housed, the work of **housing stabilization** begins.

- **Case managers or community/housing support teams**--helping clients learn to live in housing, pay rent on time, get along with neighbors, and perform basic tasks such as shopping and minimal cooking.
- **Linking to benefits and services**--helping clients access public benefits for which they are eligible if the clients do not already receive them, helping clients to make and keep health care appointments and follow recommended treatment.
- **Keeping housing units in good condition**--helping newly housed clients learn to maintain their unit so it does not attract vermin and is free of fire hazards.
- **Creating a support system**--buildings dedicated to PSH often also include common rooms, communal activities, and tenant governance organizations to help make the building’s residents into a community, as well as easy access to staff.

1.2.3. Early and Ongoing Health Care for Permanent Supportive Housing Tenants

Services for those already in PSH and for those still homeless ideally include care for physical and behavioral health conditions, although actual provision of this care varies widely, as described later in this paper. These health care activities include:

- **Primary care includes**--ongoing treatment for acute and chronic health conditions; preventive health care; and medications management, including clinical pharmacy services to help avoid over-medication and negative side effects from conflicting medications. Dental care is often the top health care need. Vision and hearing care are often needed, for homeless people of every age but especially for those who are getting older. Primary care is provided by health care professionals, usually in clinics but sometimes through outreach. Increasingly PSH providers seek to incorporate primary care into their supportive services structure, but, for most PSH residents, primary care remains largely outside that structure.

- **Mental health services include**--counseling and coaching to reduce social isolation and restore functioning impaired by mental illness; assessment and support for recovery and self-management of symptoms and medications; prescribing and adjusting medications; being alert to signs that clients are beginning to have problems related to the symptoms of their mental illnesses; intervening with crisis counseling; and offering respite or urgent care if needed. Mental health services are provided by mental health professionals and sometimes by paraprofessionals and peer counselors, usually from mental health service agencies but sometimes on the staff of PSH housing providers.
- **Services to address substance use disorders include**--Alcoholics Anonymous/Narcotics Anonymous or other peer support, detoxification, harm reduction/stages of change strategies, and residential treatment. Services may involve motivational interviewing, individual and group counseling, and coaching. The intent is to help people establish recovery or harm reduction goals and to achieve and maintain them. In today's PSH, this work is done mostly by staff of PSH service-provider agencies and by integrated treatment teams. Rarely do chronically homeless clients go to residential treatment programs, but they have often used detoxification and sobering centers before entering housing.

1.2.4. Care Coordination and Integration

An essential but not always achieved element of services for residents of PSH involves keeping all the activities related to health care on the right track and working to complement each other rather than in isolation or opposition. Care coordination and integration start with considering a prospective client's "whole picture" from the beginning, when the agency makes the decision to enroll people in its programs and engages them in identifying their own needs, goals, and priorities. Activities include team meetings and case conferences, records integration, attention to care transitions, and ongoing in-home contact. Care coordination often involves cross-agency connections and teamwork.

2. THREE GROUPS WITHIN THE CHRONICALLY HOMELESS POPULATION

As noted in the Introduction, chronically homeless people's access to health and behavioral health services varies greatly depending on client characteristics, which in turn affect whether a person is eligible for Medicaid. Because this paper's focus is the potential to have Medicaid contribute its resources to the support of people living in PSH, the analytical focus is on how client characteristics affect the likelihood of PSH tenants being eligible for Medicaid in general, and also for specialized mental health service options within Medicaid.

We approach this issue of "Who gets what?" by dividing the overall population of chronically homeless people with disabilities into three groups based on their likely Medicaid eligibility:

- **Group 1--those who do not qualify for Medicaid enrollment.** Homeless people in this group are poor enough that they will qualify for Medicaid in 2014, but in 2012 they are not eligible for Medicaid in most states. A few states have expanded Medicaid eligibility for members of this group by implementing Affordable Care Act (ACA) eligibility provisions more quickly or using Medicaid waivers to serve people who are not categorically eligible.
- **Group 2--those who qualify for Medicaid, usually because they are disabled and also qualify for SSI AND who do NOT qualify for Group 3 because they do not have a serious mental illness (SMI).** Some people are in this group because they qualify for Medicaid on the basis of having a disability, even though they are not SSI beneficiaries, or because they live in a state that has expanded Medicaid eligibility.
- **Group 3--those who qualify for Medicaid and also for specialized mental health services** because they have a mental illness that meets a state's medical necessity criteria for access to such services.

Exhibit 1 displays the criteria for membership in the three groups and describes the types of health and behavioral health care that Medicaid is likely to cover for each group. Section 4, Section 5 and Section 6 of this paper provides additional details on the supportive service funding sources and providers for each of the three groups.

Information about the likely size of each group within the chronically homeless population is spotty. At present, the best data available on chronically homeless people's Medicaid enrollment come from the 100,000 Homes Campaign (<http://www.100khomes.org>), which surveys people mostly living on the streets of many cities.

These surveys use a Vulnerability Index first developed by the Boston Health Care for the Homeless Program (BHCHP). The Vulnerability Index assesses a homeless person's likelihood of dying on the streets in the near future. It asks more than 30 questions about a person's pattern of homelessness, illnesses and health conditions, sources and use of medical and other health care, victimization, and the like, also recording demographic characteristics and veteran status. Answers are assembled into a vulnerability score (Common Ground, 2010).

To be considered chronically homeless a person had to have been homeless for a year or more or to have had four homeless episodes in the previous 3 years. Many but not all chronically homeless people were found to be vulnerable, and vice versa.

Using information from almost 19,000 Vulnerability Surveys gathered between winter 2010 and May 2011, the 100,000 Homes Campaign found that 62 percent of those surveyed were chronically homeless, 46 percent were vulnerable, and 34 percent were both. Among the chronically homeless group, **only 14 percent were enrolled in Medicaid and 48 percent said they had no insurance.**

The proportion of chronically homeless people living on the streets who are enrolled in Medicaid does not tell the whole story, however. Many chronically homeless people have physical or mental disabilities that would make them eligible for Medicaid and SSI, and some have actually been beneficiaries in the past but have lost their benefits.³ Obtaining and retaining these benefits is not easy for a homeless person, or for any person applying without the assistance of trained case managers.

Data from the 100,000 Homes Campaign indicates that 63 percent of chronically homeless survey respondents were also vulnerable; as noted above, people had to report serious health problems and/or crisis health service use to be identified as vulnerable. For this group,⁴ only 24 percent were enrolled in Medicaid at the time they were surveyed, and 30 percent had no insurance (Common Ground, 2011). Many would probably meet criteria for an SSI or Medicaid disability determination, and thus fall into either Group 2 or Group 3.

Research is also starting to provide some evidence of the proportion of chronically homeless people who have a SMI, which potentially would make them eligible for SSI and Medicaid if not already enrolled, and place them in Group 3 rather than in Group 2. A recent study of over 3,000 chronically homeless adults in Philadelphia (Poulin et al., 2010) revealed that 75 percent had a SMI, while 45 percent of respondents to Common Ground's Vulnerability Index surveys reported SMI (Common Ground, 2011). Early data from the National Survey of Homeless Assistance Providers and Clients (Burt, Aron, and Lee, 2001, Table 4.1) indicated that in 1996, 45 percent of single men and 56

3 A person can lose SSI and/or Medicaid benefits by being incarcerated, hospitalized, or residing in some other institution for a specified period of time. Benefits loss may also occur through failure to respond to requests from the Social Security Administration (SSA) or Medicaid offices for information about current income, and residential status, and Continuing Disability Reviews.

4 The "chronic AND vulnerable" people comprised 34 percent of all homeless people surveyed.

percent of single women had had mental health problems in the past year, while 53 percent and 65 percent of single men and women, respectively, had had mental health problems during their lifetime.

2.1. Likely Size of Each Group

These estimates cover a broad range, in part reflecting the different populations surveyed. Variation is also influenced by differences in methods used to collect data and among states or communities in the availability of housing and supports for people with SMI who might otherwise experience long-term homelessness. The best guess of group size, given the paucity of evidence, is that Group 1 could be as large as half the chronically homeless population or as small as 20 percent, while Group 3 could be as large as 70-80 percent of that population or as small as 40-50 percent (HUD, 2011; Poulin et al., 2010).

2.2. Likelihood of Being in Permanent Supportive Housing

In comparison to group membership in the overall population of chronically homeless people, group membership of tenants in PSH appears to be somewhat skewed toward those in Group 3, although the skew may not be very large in some jurisdictions.

A 2008 survey of all PSH programs in the District of Columbia (DC) found that 79 percent of tenants had SMI (Burt and Hall, 2009), while similar surveys of three states and three counties in 2007 found that 60 percent of PSH residents had SMI (Burt, 2008a).⁵ A separate survey of Ohio PSH indicated that more than 90 percent of PSH tenants had a mental illness, and most also had a co-occurring substance abuse problem. Data from PSH programs reporting through Homeless Management Information Systems to the 2010 Annual Homeless Assessment Report to Congress, however, show a substantially lower prevalence of mental illness among PSH residents --43 percent (HUD, 2011). Variations reflect, among other factors, the policies of different jurisdictions in the commitment of their public mental health systems to helping people eligible for their services to move into PSH.

⁵ The states of Connecticut, Maine, and Rhode Island; Los Angeles County; Portland/Multnomah County, Oregon; and Seattle/King County, Washington.

EXHIBIT 1. Differentiating Access to Medicaid-Reimbursed Health Care Among Three Groups of People*		
Criteria	Met?	Implications for Group Membership and Scope of Health and Behavioral Health Services Likely Covered by Medicaid
Q 1. Income low enough to meet requirements?	No	Not eligible for Medicaid. In some cases people may become eligible for Medicaid services if they meet other eligibility criteria and “spend down” some of their income by paying a “share of costs” for Medicaid-covered services.
	Yes → ask Q2	In 2011, the median income cutoff for Medicaid across the 50 states and DC was 64% of the federal poverty level (Heberlein, Brooks, and Guyer, 2011). In 2014, the ACA will make all people with incomes at or below 133% of poverty eligible on the basis of income. This will include virtually all homeless people. Medicaid coverage for these newly eligible people may be offered through “benchmark” benefit packages that offer at least “essential benefits.” Services covered by benchmark benefit packages are usually more limited than regular Medicaid as to type and intensity/frequency. Some services needed by chronically homeless people, particularly services delivered outside of doctors’ offices, clinics, or hospitals, may not be covered.
Q2. Meet requirements for Medicaid eligibility on basis of disability or other “categorical” eligibility criteria?	No →	GROUP 1 Not Eligible for Medicaid in most states, where Medicaid is available to single adults only if they are in a group with “categorical” eligibility (e.g., disabled or elderly, or pregnant). Exceptions include Medicaid eligibility now in states that decided to implement ACA eligibility provisions more quickly or have waivers to serve people who are not “categorically” eligible.
	Yes → ask Q3	Medicaid-eligible. Usually people meet this requirement by establishing eligibility for SSI, which also provides an income source. Otherwise they must meet the same disability criteria as for SSI, but assessment is by a Medicaid eligibility office, not the SSA; it usually takes less time and is not as difficult, but does not include any cash benefit.
Q3. Meet requirements for specialized mental health services, as established by the medical necessity criteria specified in a state’s Medicaid Plan for these services.	No →	GROUP 2 Qualify for Medicaid, but not for specialized mental health services. Medicaid service coverage for people in this group, who have “categorical eligibility,” is more comprehensive than the “benchmark benefits” or “essential benefits” that will become available to Group 1 in 2014 and are available to some people in some states now. However, Group 2 people are unlikely to be eligible for extensive behavioral health services or care coordination for people with multiple health needs.
	Yes →	GROUP 3 Qualify for Medicaid, and for specialized mental health services. Medicaid-eligible, and also qualify for specialized mental health services plus the same full Medicaid benefits available to those in Group 2. Many state Medicaid programs have authorized rehabilitation services for eligible clients, whether homeless or not, that come closest to meeting the needs of chronically homeless people and formerly homeless people residing in PSH. State and county mental health agencies often target as their clients the population eligible for these specialized mental health services. The services can and often do cover intensive and extensive treatment and supportive services to stabilize symptoms and help clients recover/move toward stable community residence. Persons in this group will most likely have SSI or Social Security Disability Insurance already, but if not, providers will be able to help them get it.
* These categories apply to any adults seeking Medicaid eligibility, including the chronically homeless people on whom this study focuses.		

3. HOW THE SUPPORTS IN PERMANENT SUPPORTIVE HOUSING WORK

3.1. How Care is Delivered

Members of all three groups may receive care and supports in a number of ways. The scope and intensity of supportive services to PSH tenants varies substantially from one provider or community to another, probably almost as much as it varies among members of Groups 1, 2, and 3, although funding limitations make it difficult for PSH programs to offer comprehensive health services if most tenants are uninsured. Some of the most common approaches rely on case managers, often but not always attached to housing locations. Other arrangements involve interdisciplinary teams comprising staff from several parts of a single agency, two or more partner agencies, or even a whole community. Basic arrangements are therefore described here, starting with case management, which can take many forms.

3.1.1. Case Management

Some arrangements rely primarily on case managers. All receive appropriate training and supervision, though they may or may not have professional licenses. At a minimum, case managers in PSH conduct assessments, work with clients to develop a care plan, make referrals, and pursue related activities that help people get needed services. They monitor progress, and follow up to see how things are going. Most PSH case managers go well beyond this minimum, providing some direct services such as coaching, skill-building, and motivational interviewing, as well as linking clients to off-site clinical care and other community supports. PSH service-providers often describe “doing whatever it takes” to establish trusting relationships. They also usually coordinate and advocate for clients to help them access and use the most appropriate health and behavioral health care and link them to social services and income entitlements. Some case managers perform a variety of specialized functions, shown in the text box.

Specialized Case Management Functions

- Doing “whatever it takes” to establish trust, restore hope, and reduce social isolation.
- Providing motivational interviewing, crisis intervention and coaching in recovery and relapse prevention.
- Working with landlords and PSH tenants to resolve issues that might otherwise lead to a loss of housing.
- Providing “medical case management” to PSH tenants with major medical problems, including help to link to primary care, get van service to get to appointments, manage oxygen tanks, and similar activities. Case managers are often the only staff working regularly with PSH tenants who can bring back information on the results of primary care visits and integrate that information into ongoing tenant supports.
- Helping PSH tenants build skills for wellness and self-management so they can handle their own appointments and ongoing care.

3.1.2. Supportive Services Teams

Agencies working with chronically homeless people have developed a variety of team structures. Teams are most often interdisciplinary, with team members having different skills. Outreach is often done in teams of two or three, including staff with skills in the areas of mental health, substance use, public benefits, peer support, and emergency medicine. It is also common in all-PSH buildings for case managers and property management staff to work as a team, bringing their unique perspectives and knowledge of clients together to avert housing loss.

Integrated Care--Structures for Serving Any Chronically Homeless Person

Agencies that serve clients with Medicaid are most likely to offer care that integrates health, mental health, and substance use services. As a consequence, persons in Group 3 are the most likely to get integrated care. However, some integrated care structures have been developed that bring together multiple agencies to serve a broad range of homeless people, many of whom do not have Medicaid. One example is the South Middlesex Opportunity Council, described in the text box.

South Middlesex Opportunity Council (SMOC)

- SMOC is a collaboration involving 19 programs in the southwest Boston suburbs that provides comprehensive services to homeless individuals and families.
- SMOC formed the Common Ground Resource Center to integrate its rich array of services for individual clients, and began to use a relapse-sensitive, harm reduction-oriented “Housing First” model to end homelessness for individuals.
- Major components of SMOC’s service response are outreach to people living on the streets and in emergency shelters; assistance to qualify for Medicaid-MassHealth and SSI; primary health and behavioral health care; a continuum of community-based housing options; and employment and/or education services once individuals are housed.
- SMOC’s Common Ground Resource Center holds regular meetings of up to 20 team members representing different service components, at which clients in every homeless program are reviewed and new cases are assessed and service plans developed. As needed, service plans are adjusted and coordination across participating organizations assured.

3.2. Where Care is Delivered

Care for people in all groups may occur in a variety of locations in relation to housing:

- In the client’s home--case managers or teams visit clients in their own apartments, whether scattered throughout the community or in buildings dedicated to PSH or mixed-use buildings.
- In the client’s building, but not in the client’s own unit--dedicated PSH and mixed-use buildings provide office/treatment/counseling space for case managers and

teams, and sometimes also for primary care clinicians, psychiatric nurses, social workers, employment agency staff, benefits eligibility workers, and the like. The people providing these services may have their primary offices in the building or may be part of a mobile team that rotates among locations.

- Outside the client's building, but in the immediate neighborhood--a team may work out of a nearby storefront, or park mobile vans in the vicinity of one or several PSH buildings at predictable times, and clients visit them there.
- In clinic settings--clients come to the clinic to get care or to see their case manager or treatment staff. Clinic settings may be close to PSH buildings or in neighborhoods where many clients live in scattered-site PSH. These settings may be devoted entirely to clinical functions or located jointly with more social activities such as a drop-in or resource center.

Clients often receive health and behavioral health care in more than one location--care delivered closer to where clients live is sometimes used to establish a relationship during which the provider urges clients to "come visit me" in a clinic setting. Some providers find that care delivered where clients live is very effective: clients get the care they need and not either the wrong care, too much care, or too little care. Further, they believe that clients like it. On the other hand, some providers fear that offering clinical care where people live moves too much in the direction of re-creating residential treatment institutions. The latter providers work with clients to teach them how to manage their own health care and their relationships with health care providers.

3.3. Some Supportive Housing Models Serve All Three Groups of People

In many communities, some PSH serves all three groups of chronically homeless people--whether or not people are eligible for or enrolled in Medicaid, and whether or not people have a SMI that makes them eligible to receive specialized mental health services. Before we describe the types of housing and services most often available to members of each group, we will describe some program models that serve chronically homeless people who are in *all three groups*.

PSH that is available to all three groups of people may be implemented in any of the three housing configurations (dedicated building, scattered-site, and mixed-use) described in the Introduction. It is important to keep in mind that these PSH service-providers rely on other, non-Medicaid sources of funding to pay for services in these programs, and may receive Medicaid reimbursement for only a portion of the services they deliver to some of their tenants. In a study of PSH in six communities in 2007, Medicaid, local public agency contracts, and HUD SHP grants contributed about equal shares to PSH services funding, and still made up only three-fourths of all service funding reported (Burt, 2008a, Table 3.7). It is rather common for PSH projects to

assemble ten or more different funding sources to support the services their tenants need.

Agencies that provide PSH to people in all three groups often are not qualified Medicaid providers. If they want to integrate care for their tenants, they need to partner with other agencies to offer the full range of behavioral and primary health care services. Common arrangements include: (1) having strong, well-established partnerships with other agencies to cover all the pieces; and (2) offering the housing as well as very comprehensive services within their own walls. Through these arrangements many PSH providers are able to serve the entire spectrum of homeless and chronically homeless people. For tenants without insurance coverage at first contact, these agencies have become skilled at helping clients qualify for benefits and also for SSI if they are in Groups 2 and 3. Additional details on their services and ability to use Medicaid to cover service costs are available in the second paper in this series, *Medicaid Financing for Services in Supportive Housing for Chronically Homeless Persons: Current Practices and Opportunities* (Wilkins, Burt, and Mauch, 2012).

3.3.1. Integrating Primary Health Care with Behavioral Health Services for People

One of the greatest challenges for providing the full range of services that PSH residents need is integrating behavioral health care with primary health care. Relatively few mental or behavioral health providers working with PSH tenants offer primary care services through their own staff or through established partnerships with a medical care provider. Instead, these providers refer tenants to local community clinics or other health care providers for primary care. Such arrangements often mean that behavioral health providers do not have information they need about their clients' physical conditions or care received for them, despite the best efforts of case managers to get this information when they accompany clients to primary care appointments. Conversely, these arrangements almost always mean that primary care providers do not have sufficient information about their patients' behavioral health conditions and treatment that may be affecting their physical health, including prescribed medications that will interact in unknown and perhaps harmful ways with anything the primary care physician may prescribe. None of this is good for PSH tenants.

To address this problem, some PSH service-providers have integrated primary health care with mental health and addictions recovery services to create holistic, integrated service teams. Site visits for this study and other experiences suggest that full (or very close to full) integration is most likely to happen when the same organization employs both medical and behavioral health staff and is able to integrate client records as well as staff across different service departments. The organizations able to establish this configuration are most commonly federal qualified health centers (FQHCs), but sometimes behavioral health service-providers hire primary care staff to be part of these integrated health care teams. Alternatively, FQHCs or other primary care agencies and behavioral health service-providers create partnerships, each hiring staff within its organization's area of expertise and available funding and, working together, they create highly integrated multi-agency health care teams.

Partnership arrangements that provide the various components are unique to each community and depend on agency capacities and interactions developed over many years. Examples visited for this study include both partnerships and umbrella agencies. Organizations participating in partnerships may include two or more of the following:

- Housing developers or housing management companies.
- Mental or behavioral health agencies.
- Agencies that offer primary care such as FQHCs, Community Health Centers (CHCs), and Health Care for the Homeless (HCH) programs. Dental, vision, hearing, and clinical pharmacy services are sometimes also included.

Partnerships

- **Boston Health Care for the Homeless Program (BHCHP)** is integrated both vertically within the health care system and horizontally across the larger world of social welfare, community service, and PSH agencies in Boston. Its primary health care site is at Boston Medical Center, the largest safety net care system in Boston. It also is affiliated with Massachusetts General Hospital and Partners Healthcare System, the largest private health care system in Massachusetts. Treatment and supportive services teams include physicians, physician assistants, nurse practitioners, nurses, case managers, and behavioral health practitioners. Activities and locations cover the range of outreach and engagement, clinical care (at 75-80 locations including the streets and client homes), dental care with on-site laboratory services, pharmacy and lab services, vision services, support for PSH tenants in their own home, medical respite care, and housing. BHCHP's clinical and community support teams (CSTs) helped move over 300 BHCHP clients into housing run by numerous partners offering PSH.
- **Lifelong Medical Care**, a CHC in Oakland serving that city and other parts of Alameda County, California, is an FQHC providing primary care. Over many years Lifelong has developed partnerships with PSH providers and a mental health agency to offer integrated care to PSH clients and homeless people. Lifelong employs staff who work full time or several days a week in site-based PSH buildings. Staff members include a licensed clinical social worker (LCSW) who provides counseling for mental health and substance abuse problems, and social workers or case managers who help tenants with a range of issues related to housing stabilization, access to benefits and social supports, and engagement and linkage to health and treatment services. At some PSH sites collaborating partner agencies provide additional on-site services.
- **The San Francisco Department of Public Health's (SFDPH's) Housing and Urban Health Clinic (HUH)** works with the department's Direct Access to

Housing (DAH) program and numerous other PSH providers. HUH is an HCH FQHC. Most of its staff are doctors (including psychiatrists) and mid-level practitioners or nurses; HUH employs relatively few case managers who are not licensed. HUH nurses work at several PSH sites, where they assess and monitor health needs of tenants and help with medication management. PSH sites that are part of the SFDPH DAH program usually also have on-site case managers employed by a partner organization that is a community mental health services provider at some sites and a homeless service-provider at other sites. On-site case managers are funded through HUD supportive-services-only grants and/or county funding through SFDPH.

- **Community Housing Partnership (CHP)** in San Francisco exemplifies a model of a project-based PSH provider that delivers housing and services in its own buildings and sometimes in other buildings in partnership with other housing and/or services providers, and works with other partners to offer specialized services. CHP's primary mission is providing PSH to homeless people. CHP sometimes partners with the SFDPH to provide on-site case management services in PSH buildings that are part of SFDPH's DAH. CHP is just now getting certification as a "non-traditional" provider of Medicaid mental health services and will begin billing for clinical mental health services for tenants with SMI. CHP's newer PSH projects focus on homeless seniors and people with high levels of medical need. The city's referral process and priorities have resulted in increasing numbers of PSH tenants with very long histories of homelessness and high rates of chronic medical conditions, including cardiovascular conditions, diabetes, and long-term effects of physical injuries and pain. Many tenants have long histories of alcoholism in addition to medical problems, and need "medical case management" including help to link to primary care, get van service to get to appointments, manage oxygen tanks, and similar issues.

Umbrella Agencies

Umbrella agencies supply all the care, having within their organizational structure all the components needed to support PSH tenants. Such organizations create and operate their own housing or arrange for housing in the private market, do integrated behavioral health and primary care, and operate using an integrated team structure that includes housing staff.

- **Heartland Health Outreach (HHO)** in Chicago is an arm of Heartland Alliance, which also has arms that develop affordable housing, provide extensive family supports, help households increase their economic security, and offer legal advocacy. Services of all arms are available to PSH tenants who need them. HHO offers primary health care as an FQHC. It provides mental health and substance abuse services under two different state Medicaid rules, and has developed and runs its own Safe Haven and project-based PSH. It offers health care at dozens of locations, including its own PSH and PSH run by other

organizations; conducts extensive street and other outreach including with its medical services; and facilitates its clients' applications for SSI and Medicaid.

- **Community Healthlink** in Worcester, Massachusetts is a comprehensive home and community-based services (HCBS) agency affiliated with the University of Massachusetts Memorial care system, working in the greater Worcester and Central Massachusetts area. Community Healthlink provides a full range of services delivered to persons with mental health and substance use conditions through four operating divisions--youth and families, adults, residential services, and homeless services. Homeless services center around the Homeless Outreach and Advocacy Project, which links homeless persons to many Community Healthlink services including health screenings and evaluation, health care counseling, substance abuse detoxification and rehabilitation, the Homeless Emergency Assessment and Response Team, its crisis stabilization units, and referral to other support systems. Community Healthlink integrates the behavioral health care provided through its community mental health center (CMHC) with the primary health care offered at its HCH program and two affiliated FQHCs for families and individuals. The Community Healthlink model of care integrates primary care, behavioral health care, dental care, and case management services.

Being in the same umbrella organization does not always resolve all the challenges of integrated health care. Even when the same organization provides both primary care and behavioral health services, program funding and/or certification rules may require the organization to provide these services in separate programs or components that may have separate eligibility criteria, reimbursement mechanisms, staff and clinical supervision, and sometimes separate locations. In Chicago, for instance, HHO must maintain a specific space that is certified for substance abuse treatment. To be reimbursable under Medicaid, all care related to substance use must occur in that space--even though an integrated team member who usually works in that space could easily walk one block to work with a client in his or her own housing, if that client were unable or unwilling to come to the designated location.

Fully integrated models of health care have some important advantages from the perspective of engaging clients and ultimately being able to address all of their needs. Each component of integrated health care offers a separate access point, some of which may initially be more acceptable to potential clients than others. For example, some chronically homeless people with SMI are initially unwilling to accept a mental health diagnosis or mental health treatment, but will accept care for medical problems such as skin conditions or upper respiratory illnesses, or may be motivated to seek care because of more serious and life-threatening medical problems such as cancer or heart disease. If the person meets a primary care clinician who offers sensitive and non-judgmental care to address medical problems, the essential element of trust can be established and primary care can be the "door" to treatment for other problems.

4. GROUP 1: POOR ENOUGH BUT NOT ELIGIBLE FOR MEDICAID

Under current conditions, people in Group 1 are often the least well-served among the chronically homeless population in many communities. This group includes some people with very high levels of unmet health needs, because they have limited access to health care or treatment services because they are uninsured, or they may be disaffiliated from formal care systems, having tried them and decided to avoid them. Many are adults with chronic substance use disorders, who have not been eligible for SSI since January 1, 1997. At that time, a change in federal law and SSI regulations began disallowing primary diagnoses of substance abuse as well as of conditions to which substance use “contributes materially.”⁶

As a result, as of 2011, a large number of chronically homeless people have been ineligible for Medicaid in most states. A few states have used a Medicaid 1115 waiver to expand coverage to those who are not “categorically eligible,” including those whose substance use disorder is their primary diagnosis. These policies put the people affected into this paper’s Group 2, discussed below.

Nearly all people in Group 1 will become eligible for Medicaid in 2014, or sooner in states that are moving more quickly to expand eligibility. It is thus important to understand who they are and what their health and behavioral health needs might be.

Within this group, the target or priority populations for PSH may include:

- Very vulnerable homeless people living on the streets or in emergency shelters for many years--particularly those who have serious long-term substance abuse problems and health conditions or risks associated with substance abuse (including liver disease and cold-weather injuries).
- Uninsured homeless patients being discharged from hospitals (sometimes with stays in medical respite).
- Frequent users of hospital emergency rooms, avoidable hospital inpatient care or readmissions, detoxification services, emergency response teams, and other costly services.
- Homeless people with recent or past histories of incarceration, some of whom may cycle among jails and shelters.

⁶ If a disabling impairment would still exist if the person stopped using drugs or alcohol, it is acceptable as a basis for SSI eligibility. If, however, drug abuse or alcoholism is deemed “material” to the disability because evidence establishes that the person would not be disabled if the drug or alcohol use stopped, the condition is not a basis for SSI eligibility, and an application would be denied (Post et al., 2007).

4.1. Supportive Services Funding for People in Group 1

Because they are not eligible for or enrolled in Medicaid, people in Group 1 will most likely receive health care and behavioral health services that will be less intense and less comprehensive than services that are available for people covered by Medicaid. In some cases, PSH service-providers use non-Medicaid funding to offer the same services to PSH tenants regardless of whether they are enrolled in Medicaid. Because they are uninsured, PSH tenants in this group often encounter significant barriers that limit access to prescription drugs and to health care or treatment services from other providers, making it difficult for PSH case managers to make referrals and facilitate connections to needed care and support. PSH service-providers cannot obtain Medicaid reimbursement for services they provide to this group of people. Instead supportive services for these PSH tenants may be funded through some or all of the following sources:

- HUD grants that cover supportive services, usually through the SHP.
- State and local tax revenues, through the budgets of state and/or local governments--some of these funds may be dedicated specifically to ending homelessness, while others are designated for serving people with particular health needs, some of whom will be homeless.
- Grant funding to HCH programs and CHCs through the U.S. Department of Health and Human Services' (HHS's) Health Resources and Services Administration.
- Grant funding through HHS's Substance Abuse and Mental Health Services Administration (SAMHSA) grant funding--including competitive grants for services in supportive housing or treatment for homeless people, resources allocated through the Mental Health and Substance Abuse Block Grants, and grants for Projects for Assistance in Transition from Homelessness.
- Foundation grants, United Way allocations, and private fundraising.

4.2. What Agencies Are Most Likely to Serve People in Group 1?

Chronically homeless people in this group are often served in PSH that does not deliver Medicaid-reimbursed services, as well as in PSH models (described earlier) that serve homeless people in all three groups. People in this group will not, however, live in PSH that restricts occupancy to people who qualify to receive services funded through state or local mental health agencies. Also, this group will not be eligible for SSI. Members may have at least some modest income from sources such as General Assistance benefits or part-time employment. But if they have no income, PSH

providers often are reluctant to accept them as tenants, because they have no way of paying for any aspect of their housing costs, and service-providers may be unable to access payment for providing needed care and support.

Basic supports to this group start with case management, and extend to primary and behavioral health care to the extent that non-Medicaid funding will cover such supports. In addition to case management, services for people in Group 1 may focus on managing chronic alcoholism or other severe substance abuse disorders through strategies such as Harm Reduction techniques and Motivational Interviewing. Medical and behavioral health services address unmet needs, which may be significant. Services may also include benefits advocacy, legal assistance, vocational/employment supports, and activities to facilitate community reintegration.

5. GROUP 2: ELIGIBLE FOR MEDICAID BUT NOT FOR SPECIALIZED MENTAL/BEHAVIORAL HEALTH SERVICES

Many PSH tenants who are Medicaid recipients will have qualified because the SSA has determined them to be disabled enough to qualify for SSI, and being an SSI recipient makes them “categorically eligible” for Medicaid. In some states, chronically homeless people will have qualified for Medicaid and fall into Group 2 because their state offers Medicaid coverage under a waiver to people who are not categorically eligible, or because their state has chosen to implement the income requirements of the ACA before 2014 (when all states are required to do so).

Medicaid waivers offer states substantial flexibility in determining the people they will cover, within categories and for reasons acceptable to HHS’s Center for Medicare and Medicaid Services. For example, both Massachusetts and Maine have Medicaid waivers under which they cover substantial numbers of currently and formerly chronically homeless people. The array of services available to some people who are enrolled waivers may be more limited than the full array of Medicaid services available to people enrolled under other eligibility criteria. Early implementers of the ACA such as DC, Connecticut, and Minnesota have also begun to extend coverage.

Many chronically homeless people have significant physical disabilities or disabling medical conditions. They do not, however, have a psychosis or major affective disorder and thus will usually not be eligible for specialized mental or behavioral health services. This means that public mental health systems will not be centrally involved in ending their homelessness. Many people in Group 2 do have cognitive impairments, serious and long-term substance use disorders, histories of trauma, and less severe mental health problems as well as physical health conditions. Medicaid costs can be very high for some homeless people in this group who receive care in hospitals, emergency rooms, detox facilities, and other settings for health crises that could be avoided if people received more appropriate and effective care and support.

When outreach and service-providers first encounter people who qualify for Group 2, they usually are *not* Medicaid recipients. However, with increasing contact and interactions, providers may determine that the people they are working with have chronic illnesses and disabling conditions that are enough to qualify them for SSI and, therefore, Medicaid. This happens most frequently with providers who are among the growing number that have worked closely with local SSA and state Disability Determination Services offices to improve their approach to applying for SSI (see Burt and Wilkins, 2011). In addition, some people in Group 2 have reached the age of 65 and thus qualify for Medicare and, if poor enough, also for Medicaid, regardless of their level of disability. Eligibility for Medicaid distinguishes people in Group 2 from those in Group 1.

Target populations for PSH within Group 2 include:

- Very vulnerable homeless people living on the streets, particularly those who have serious medical conditions complicated by long-term substance abuse problems (County of Los Angeles, 2010; Moore, 2006; Streblick, 2007).
- Homeless patients being discharged from acute care hospitals (sometimes with stays in medical respite) and those who are being diverted or discharged from skilled nursing facilities (Burt, 2008b, Chapter 5, for Central City Concern Recuperative Care Program and Seattle/King County's Medical Respite Program).
- Frequent users of hospital emergency rooms, avoidable hospital inpatient care or readmissions, detoxification/sobering services, or other costly services (Corporation for Supportive Housing, 2010; Larimer et al., 2009; Linkins, Byra, and Chandler, 2006).
- Homeless persons with HIV/AIDS or other specific health conditions (Aidala et al., 2007; Buchanan et al., 2009; Sadowski et al., 2009; Schwarcz et al., 2009; Wilkins and Bamburger, 2009; Wolitski et al., 2009).

5.1. Supportive Services Funding for People in Group 2

People in this group will most likely enter PSH that has been developed by (or in partnership with) a homeless service-provider, a HCH program, an affordable housing developer, or an organization that provides a fairly comprehensive array of social services such as a community action agency.⁷ These agencies often provide PSH to people in all three of the groups described in this paper, using housing resources and supportive services funding streams that are not restricted to people with SMIs or those who are enrolled in Medicaid. In comparison to Group 1, however, access to supportive services is likely to be much easier for members of Group 2. PSH service-providers may be able to receive Medicaid reimbursement for providing covered services to them, and enrollment in Medicaid makes it easier for them to get prescribed medications and access to additional health care or treatment services from other providers in the community.

⁷ Since they do not have SMI, they are not eligible for PSH run by mental health agencies that operate programs that rely on funding that can be used only to serve people with SMI.

5.2. What Agencies Are Most Likely to Serve People in Group 2?

The agencies that provide PSH for the chronically homeless people in Group 2 usually are not themselves qualified as Medicaid providers. Rather, their tenants in Group 2 are most likely to receive Medicaid-reimbursed services through a FQHC--an HCH program or CHC--that partners with a housing provider. FQHC providers receive Medicaid reimbursement for encounters between Medicaid-eligible people and clinicians such as doctors, psychiatrists, mid-level practitioners (nurse practitioners or physician's assistants), and LCSWs. A basic challenge with this financing mechanism is that it does not usually cover the cost of the care coordination services, or "glue," provided by case managers who work with PSH tenants. In addition, depending on each state's specific Medicaid plan, some FQHCs may not receive reimbursement for behavioral health services provided by LCSWs.

In Massachusetts, where virtually every homeless and formerly homeless person can qualify for Medicaid on the basis of low income, coverage for most behavioral health services is "carved out" and administered by the Massachusetts Behavioral Health Partnership (MBHP). Unlike "carve-out" arrangements in many other states, MBHP is responsible for a broad array of behavioral health services to meet the needs of people with or without SMIs. MBHP contracts for behavioral health services using a variety of unit and bundled rates. In one initiative, targeted to persons who meet the federal definition of chronic homelessness, MBHP reimburses providers of community support program services through a bundled daily rate, rather than requiring discrete billing for each 15-minute encounter as was earlier the case. This daily rate is set at a level that covers activities that help maintain contact with clients and with service team members, to assure that supports are delivered in an integrated manner. Through MBHP, Massachusetts is able to provide Medicaid funding for the range of services needed by PSH tenants in Group 2 who qualify for behavioral health services on the basis of substance abuse or mental health problems but who do not have SMI.

6. GROUP 3: ELIGIBLE FOR SPECIALIZED MENTAL/BEHAVIORAL HEALTH SERVICES UNDER MEDICAID

The condition known as “serious mental illness” differentiates Group 3 from Groups 1 and 2. SMI usually involves a **diagnosis** of psychosis or major affective disorder and **duration** of at least a year, either already experienced or anticipated. Along with these two elements, the condition must create substantial **disability**, meaning that it significantly impedes a person’s ability to function in the world, including earning enough to be self-sufficient and be able to take care of oneself.

Currently available housing and service structures appear to best serve chronically homeless people, with an SMI; many PSH programs serving Group 3 operate under the umbrella of public mental health systems, as opposed to providers in homeless assistance systems that provide most of the PSH serving Groups 1 and 2. Why, among chronically homeless people, are those with SMI best served by current structures? At least four reasons suggest themselves. First, public service agencies exist--state and local mental health authorities--that are charged with assuring the safety and well-being of this group of people. SMI is the standard against which state mental health authorities judge an adult’s eligibility for public mental health services. Eligibility carries with it access to specialized mental health services and, in some jurisdictions, also access to various types of housing.

Second, long-term residential care has historically been a responsibility of public mental health agencies, carried out (though not always necessarily well), through state or county mental hospitals or other residential care facilities. Only the U.S. Department of Veterans Affairs has responsibilities even roughly comparable to public mental health agencies and, until very recently, its responsibilities did not extend to providing permanent housing or ending homelessness. No other agencies with a similar charge exist for most other people with disabling physical conditions or substance use disorders.

Third, the SMIs of people in Group 3 qualify them for SSI--a critical source of financial support--in addition to the services of state and local public mental health systems.⁸ SSI gives people in Group 3 an income from the federal program, as well as supplements for certain types of housing arrangements in some states. Providers who

⁸ Eligibility is never guaranteed, however, because SMI can be a moving target--both state mental health authorities and SSA, which administers SSI, have gone through periods of greater and lesser inclusiveness in the level of severity and the duration of the condition they require to qualify someone for benefits (Livermore, Stapleton, and Zueschner, 1998; Rupp and Stapleton, 1998). These pendulum swings are usually in response to either budget considerations, which push in the direction of tighter controls and fewer people being approved for benefits, or concerns that people who are “eligible on paper” are being denied, which push in the direction of more-lenient cutoffs and greater inclusiveness.

serve the people in Group 3 often have the clinical documentation to help them establish eligibility for SSI. With SSI income, chronically homeless people with SMI can help pay for their own housing, making it more financially possible for mental health service agencies to offer housing.

Fourth and finally, SSI qualifies chronically homeless people with SMI for Medicaid and often for specialized mental health services, providing a funding source for services that supplements county mental health contracts and federal grants, if the service-providers already are or are able to become certified as Medicaid providers.

People with SMI and the mental health agencies that serve them were the focus of three major research-demonstration and systems-development efforts in the early days of PSH (1990-1995). Those efforts examined the question of what types of housing worked for people with SMI, as well as what aspects of public systems were best able to guide homeless people with mental illnesses toward supportive housing and help them to stay there. They were:

- Demonstrations in five communities to examine promising practices in housing-plus-services for people with SMI (Shern et al., 1997), funded by the National Institute of Mental Health under a mandate included in the Stewart B. McKinney Act of 1987.
- A complex demonstration program, the Robert Wood Johnson Foundation (RWJF) Program on Chronic Mental Illness, co-funded by the RWJF and HUD. In Ohio, the demonstration was a partnership with the Ohio Department of Mental Health (DMH) to establish PSH programs for homeless people with SMI in nine Ohio cities (Goldman, Morrissey, and Ridgeley, 1994).
- The ACCESS demonstration in nine intervention and nine comparison communities had the same purpose (Randolph et al., 2002; Rosenheck et al., 2002; Rosenheck et al., 1998).

The results of all three demonstrations helped to establish PSH as a useful practice for homeless people with SMI. They had the additional outcome of helping the participating communities to establish working relationships among previously isolated agencies, many of which evolved into today's most well-established and innovative integrated services models.

Also contributing to the focus on homeless people with SMI were large public investments such as the New York/New York Initiative, the Special Homeless Initiative in Massachusetts, and California's Integrated Services for Homeless Adults with Serious Mental Illness program (known locally as "AB 2034" after the Assembly bill that created it).

- The New York/New York Initiative, begun in 1991, is a city-state agreement, now in its third iteration and negotiating its fourth, to fund PSH for people with SMI in New York City. (Houghton, 2001).
- Massachusetts's Special Homeless Initiative began in 1992 with a \$1 million legislative appropriation to the DMH to support a pilot housing-with-services program for homeless people with SMI. It grew to more than \$20 million a year by the mid-2000s. Its funding has contributed to doubling the number of housing units for people with SMI in Massachusetts and simultaneously shifting the type of housing supported by the DMH from group homes and "treatment" settings to independent and semi-independent living in the PSH model (Burt, 2006).
- In California, AB 2034 focused on homeless persons with SMI, and programs often provided immediate offers of housing as well as the services to keep people in it. Programs throughout the state were able to get more than 80 percent of their clients off the streets, demonstrating improved well-being as well as cost savings (Burt and Anderson, 2005; Mayberg, 2003).

The evidence from early demonstrations and the lead taken by pioneering states and communities have contributed to the situation prevailing today, in which a substantial portion of the PSH created across the country is specifically targeted to adults with SMI because the money for the housing, and often the services, comes from or through, mental health agencies. Much of the funding for capital and/or operating costs of the housing component of PSH comes from the budgets of state or local (usually county) mental health agencies, which often are legally restricted to serving people with SMI. In addition, many public mental health agencies control housing resources from HUD through successful applications for SHP funds as part of annual Continuum of Care submissions, including PSH projects and Shelter Plus Care subsidies. Control over entry into housing is often through a mental health system gatekeeper, who either must refer homeless people with SMI to the PSH (after first determining their eligibility against clinical criteria) or must give final approval for people referred for PSH from community-based service-providers.

In recent years, states and communities have launched initiatives to end chronic homelessness that add some special targeting priorities to the general category of homeless or chronically homeless people with SMI. Some of these initiatives focus on reducing chronic homelessness, some focus on reducing unnecessary and expensive use of crisis public services, and some do both. The targets include:

- Very vulnerable homeless adults with SMI who are **living on the streets or staying in emergency shelters**. Many but not all have been homeless long enough to qualify as chronically homeless (County of Los Angeles, 2010; Moore, 2006; Streblick, 2007).
- Homeless **frequent users of psychiatric emergency rooms, inpatient care, or sobering centers**, or those who are being discharged from inpatient hospitals

after relatively short stays for acute medical and/or psychiatric conditions (Corporation for Supportive Housing, 2010; Larimer et al., 2009; Linkins, Byra, and Chandler, 2008).

- Homeless adults with SMI who **are cycling among jails, shelters, and street homelessness** (Burt, 2009, 2008b; Roman, Fontaine, and Burt, 2010).
- Chronically homeless persons with SMI who **“have not been engaged in or effectively served by the traditional mental health system.”** This group is a priority for California’s Mental Health Services Act (MHSA) funding (Burt, 2008c; Burt and Hall, 2010).
- Persons with SMI who **have been living in restrictive settings** (nursing homes, Institutions for Mental Disease, psychiatric hospitals, board and care facilities) and have no other housing options. Many are not homeless as defined by HUD, but may be eligible for PSH and other forms of housing assistance funded through their mental health system (Pathania, 2009).

6.1. Supportive Services Funding for People in Group 3

Agencies providing services to PSH tenants with SMI get the funds to cover service costs from many of the same sources as are used for Groups 1 and 2. Big differences for people in Group 3 include contracts from state and local mental health agencies that are supported by federal block grants or state or local general fund dollars, and the availability of Medicaid reimbursement for additional services. Medicaid coverage of specialized mental health services may be authorized under Medicaid’s Rehabilitation Option, Targeted Case Management Option, HCBS, and waivers. Definitions of service nature and scope, medical necessity or service access criteria, provider qualifications, and payment mechanisms are specified in state Medicaid plans.

Many provider agencies have performed become knowledgeable about these funding sources and skilled at “braiding” multiple sources of funding or establishing partnerships with organizations that receive other funding. They frequently describe frustrations at the ways the different funding sources refuse to “come together” to provide adequate care. Differences in eligibility criteria, covered services, staff credentials, length of services, service venues, and other factors often obstruct efforts to assemble the resources needed to provide integrated care. Other papers produced for this study (Burt, Wilkins, and Mauch, 2012; Wilkins and Burt, 2012) discuss these challenges in more detail.

In the communities visited for this study, mental health service agencies most frequently combine state or county funding for mental health services with privately-raised dollars and Medicaid reimbursement for mental health services covered under the Rehabilitation Option or a mental health or behavioral health carve-out authorized by a Medicaid waiver. For persons covered through Medicaid Managed Care, there may

also be opportunities to use a portion of the capitation payment provided to Managed Care Organizations to pay for services provided in PSH.

Combining a Medicaid Waiver and Behavioral Health Carve-out in Massachusetts

Since 1996, Massachusetts has used a Medicaid 1115 waiver to extend eligibility to everyone in the state who is poor enough. This means that virtually all homeless persons are, or can easily become, Medicaid beneficiaries. Massachusetts also has a Medicaid behavioral health carve-out operated by a managed care company, contracts under which give PSH service-providers a good deal of flexibility to cover activities that meet the needs of homeless people with SMI and co-occurring substance use disorders.

In some states, Medicaid can provide funding for case managers in PSH because the case manager functions meet the definition of “community supports” which may be covered under Medicaid’s Rehabilitation Option or a waiver. However, during site visits PSH services providers said that Medicaid frequently does not cover the activities needed to maintain contact with clients and assure consideration of all their issues. These activities include outreach, engagement, participating in team meetings, and vocational or employment services. Agencies often raise money privately for these activities.

State or county mental health contract funds are often more flexible than Medicaid. They are sometimes used to pay providers to do “whatever it takes” to engage chronically homeless persons with SMI, stabilize them in housing, and support their recovery. This includes providing services to people with SMI while they are awaiting a determination of eligibility for Medicaid. However, state mental health funds do not always cover help for co-occurring substance use disorders. Also, state budget cutbacks in recent years have made this type of funding less available, as has happened in a couple of the communities visited.

6.2. Service Structures and Agencies Uniquely Focused on People in Group 3

Frequent reference has been made throughout this paper to “specialized mental health services.” These may include a variety of service structures that serve or focus on chronically homeless people with SMI, including assertive community treatment (ACT) teams, structures in which a mental health agency is in the lead, and structures that integrate mental health, physical health, and substance abuse services with funding to cover care coordination and integration. Among the specific services that the homeless people in Group 3 may receive, but that usually are not available to people in Groups 1 and 2, are:

- Monitoring and therapeutic interventions that help clients achieve and maintain mental health-related goals.

- Helping clients develop functional, interpersonal, family, coping, and community-living skills.
- Using evidence-based techniques such as motivational interviewing to help clients use appropriate health and behavioral health services, change behaviors associated with health risks, and avoid crises that lead to loss of housing.
- Helping clients with co-occurring substance abuse disorders develop plans and strategies to prevent relapse.

6.2.1. Assertive Community Treatment and Similar Teams for People in Group 3

Some mental health agencies working with PSH tenants with SMI use ACT or similar models of team-based services. In Illinois, for instance, Medicaid reimbursement is available for ACT teams, which are supported by a psychiatrist and include at least one nurse, one person in recovery, and team members with training or certification in substance abuse treatment and rehabilitation counseling.

Illinois also provides Medicaid reimbursement for services provided by CSTs. CSTs have staffing similar to ACT but without a nurse as part of the team and with more flexibility in training or certification requirements for other team members. CSTs and their equivalents are less expensive than ACT teams because of these staffing differences.

California counties use state funding provided through the state's MHSA to establish a similar team model called Full Service Partnerships (FSP). FSPs may include case managers, a peer counselor, a psychiatric nurse practitioner, a physician's assistant (often from a partnering FQHC), an employment specialist, housing staff, a supervising social worker, and administrative support.

In the communities visited, team models for PSH tenants with SMI often incorporate a psychiatrist or psychiatric nurse practitioner who can prescribe and monitor medications. Usually, at least one team member will have a specialized role and expertise in addictions recovery or employment promotion. Team members share responsibility for a group of clients, and team meetings are used to share information and develop collaborative strategies for providing services. Staff-client ratios are usually kept at 1:10 to 1:15.

In the communities visited, mental health service-providers most often use team models such as ACT, CST, and FSP with scattered-site housing in which PSH tenants hold their own lease. The providers help their homeless clients qualify for rent subsidies in the form of Shelter Plus Care certificates, local rent subsidies, HCVs, or, most recently, Supportive Housing (VASH) vouchers for homeless veterans. Some mental health agencies and other PSH providers master-lease apartments that give landlords greater assurance that the agency will provide backup and tenant-landlord liaison services. These arrangements allow the providers to house homeless people with very

poor credit and eviction histories or criminal backgrounds that would deter most landlords from renting to them.

Mental Health Agencies in the Lead: Thresholds and Trilogy in Chicago

Two CMHCs in Chicago operate PSH programs to end homelessness and support housing retention for their clients with SMI. Thresholds and Trilogy are Medicaid providers under the state's regulation for Medicaid's Rehabilitation Option. Most formerly homeless clients of these programs live in scattered-site housing throughout the community, with rents most commonly subsidized by Shelter Plus Care. These two agencies also operate some facility-based projects for which HUD SHP grants support the housing and some of the services. Both offer integrated mental health and addictions recovery services.

These two CMHCs have long histories of serving homeless people with SMI and helping them secure and retain housing. Their work has become increasingly difficult to fund, however, due to changes in Medicaid and state funding that limit reimbursement for the time it takes to establish and maintain trusting relationships with clients. In addition, even with sophisticated providers such as these, the mental health-related care they give is not usually integrated with primary health care. Trilogy recently received a SAMHSA grant to integrate its mental health services with primary care and will be working with Heartland International Health Center (HIHC) to do so. HIHC will add a primary care provider to one of Trilogy's mental health service sites.

6.2.2. Mental Health Agencies as Leads for PSH for People in Group 3

Among the most common combinations of housing and services for chronically homeless people with SMI are structures in which a mental health agency takes the lead, as shown in the following examples.

- A mental health service agency develops and operates⁹ its own dedicated PSH projects (i.e., it owns and manages the housing), uses these PSH units to house its own homeless clients with SMI, and directly provides those clients with nearly all the community-based mental and behavioral health services they need.¹⁰
- A mental health service agency has access to rent subsidies that it uses to help its homeless clients get apartments in the private market, and directly provides those clients with community-based mental health/behavioral health services. Sometimes, the scattered-site units are located within an affordable housing complex (the mixed-use or integrated model). The rent subsidies are usually Shelter Plus Care and sometimes HCV or state or locally-funded rent subsidies for scattered-site models.

⁹ "Operating" housing means doing whatever it takes to keep rental units and buildings functional and the financial structure sound. This includes setting and collecting rents; maintaining the premises; making repairs; attending to security; assuring that heat, light, and other utilities function; paying taxes; and, if necessary, evicting tenants. The costs associated with doing these things are operating expenses. Tenant rents are one source of funds to cover operating expenses, but most PSH projects need additional funds to supplement rents if they are to cover most of their operating costs.

¹⁰ Generally psychiatric emergency and inpatient services are delivered by public systems and not by PSH service providers.

For many mental health organizations, providing supportive services in PSH has been a logical extension of their services to support recovery for their SMI clients, and an evolution of practice to incorporate PSH as a SAMHSA-approved Evidence-Based Practice for persons with SMI.

6.2.3. *Integrated Care for People in Group 3*

“Integrated care” may be said to exist when mental health, substance abuse, and primary care are delivered by staff who work together to provide PSH tenants with comprehensive care delivered with attention to the whole picture. The staff may be from a single agency or from different agencies. Dental and eye care and clinical pharmacy services are also sometimes part of the mix. Many practitioners consider integrated care to be the “gold standard,” particularly important when caring for people whose many complex and interacting conditions often do not improve unless all aspects of the client’s situation are taken into account simultaneously.

From a housing perspective, “integrated care” also needs to assure that caregivers consider housing issues as factors when making decisions about how to help a patient or client, or else the decisions will not really be based on “the whole picture.” In many of the programs visited, housing case managers were part of the team in completely integrated approaches to supporting PSH tenants.

Providing Substance Abuse Services to Chronically Homeless People with Serious Mental Illness

Challenges of integrating care for mental illness and substance use disorders are examined here, in relation to people in Group 3, because many chronically homeless people with SMI also have substance use disorders. From the client’s perspective, if both mental health treatment and treatment for co-occurring substance use disorders are needed, offering them in an integrated way is the most likely to produce improvement in both conditions. Too often, mental health providers want a person’s substance use to be “cleared up” before they will work with the person on mental health issues, and substance use treatment providers do not want to work with anyone whose mental illness is not “controlled.” The result--many chronically homeless people do not get any treatment at all.

It can be challenging to provide housing for chronically homeless people with both SMI and substance use disorders, as housing providers traditionally screen out people whose substance abuse is current. Therefore, many PSH service-providers have integrated “harm reduction” principles into “low demand” or “Housing First” models of PSH. In this type of PSH, sobriety or participation in substance abuse treatment is not a requirement for getting or keeping housing. It is often a goal of individual treatment plans, however.

Using “Harm Reduction” Principles

Heartland Alliance and HHO in Chicago and its partner, AIDS Housing of Chicago, have been working with local university faculty to develop a strategy based on Harm Reduction principles. The assessments and service protocols derived from these principles are incorporated into all program practices and make it possible to address client issues and measure progress quite precisely along dimensions of mental health, substance use, and primary care, as well as employment and other important dimensions.

Mental health service-providers working with PSH tenants nearly always incorporate some care for co-occurring substance use disorders because so many of their clients have both. ACT and similar team models usually include both mental health and substance abuse treatment expertise, and they give consideration to how the two conditions are interacting when working with clients. Funding sources sometimes cover both mental health and substance abuse care. Some states have created “behavioral health carve-outs” in their Medicaid programs, one rationale for which may be to allow integrated treatment. Nonetheless, PSH service-providers who want to integrate mental health and substance abuse services often face challenges:

- The mainstream funding and Medicaid reimbursement mechanisms for “mental health services” often do not provide payment for services that focus on substance use problems.
- Funding mechanisms for substance use services are usually limited to services provided in designated substance use treatment facilities or treatment programs. This makes it impossible to blend these sources of funding into more-flexible models that integrate attention to substance use problems with other services provided in PSH or in other settings that are not substance abuse treatment facilities.

7. SEGUE TO THE REMAINING PAPERS

This paper provides an overview of the types of chronically homeless people who may benefit from PSH and the types of care they are likely to need and receive while PSH tenants. It has not delved deeply into the details of Medicaid reimbursement for covered services, nor has it focused at all on the strategies that have been developed to facilitate this population's access to SSI and Medicaid. Other Issue Papers in this series delve deeper into issues of Medicaid (Wilkins, Burt, and Mauch, Issue Paper 2), SSI (Burt and Wilkins, Issue Paper 3), and the role of public housing agencies in ending homelessness through supportive housing for chronically homeless people with disabilities (Wilkins and Burt, Issue Paper 4).

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