

## MASSACHUSETTS STATE PROFILE

### A. Program Description

#### *Overview*

Recognizing the critical role that housing plays in stabilizing the health conditions of chronically homeless individuals, MassHealth, which administers the state Medicaid program, authorized the Massachusetts Behavioral Health Partnership (MBHP), the state's managed care behavioral health carve-out, to implement the Community Support Program for People Experiencing Chronic Homelessness (CSPECH). This program, which began operation as a pilot in 2006, provides Medicaid reimbursement for community-based care coordination support of chronically homeless individuals in supportive housing. CSPECH services are available through local partnerships of community-based providers of behavioral health and housing services. CSPECH seeks to achieve Medicaid cost savings through directing resources toward individuals in permanent supportive housing (PSH) rather than managing medical conditions on the street or in shelters. Through CSPECH, housing itself is viewed as the primary medical intervention, capturing the essence of the state's Housing First Initiative. The program's success has prompted the state to promote the CSPECH model among the other state managed care organizations (MCOs).

#### *Financing*

CSPECH services include targeted outreach and coordination support provided by a community support worker (CSW). Under Medicaid, the state classifies CSPECH services as a type of community support program (CSP).<sup>1</sup> In 2006, MassHealth approved the reimbursement of CSPECH services as a type of CSP specialty service. Unlike standard CSP services, however, which are reimbursed through a fee-for-service arrangement, MBHP reimburses CSPECH services using a flat case rate of \$17.30 per day. To date, MBHP is the only managed care entity that covers CSPECH services.<sup>2</sup> The one MCO interviewed for this study provides "social care management," which is a

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<sup>1</sup> CSP is an outreach service aimed at engaging individuals who, by not complying with a treatment plan, are putting themselves at serious risk. CSP services are typically provided to individuals being discharged from a psychiatric hospital or detoxification facility. Recognizing the value of such interventions, MassHealth received Centers for Medicare and Medicaid Services approval, through its managed care waiver program, to allow them as a reimbursable service.

<sup>2</sup> MassHealth members have the option of enrolling with either one of six MCOs or in the state's primary care clinician (PCC) plan. Under the PCC plan, MassHealth directly reimburses a member's physical health services, and MBHP pays for behavioral health services. The six MCOs are responsible for covering a member's physical health and behavioral health services, although the latter typically are provided through a behavioral health partner of the MCOs. At the time of this report, CSPECH services are available only through the PCC/MBHP plan; none of the MCOs have opted to cover this service.

telephonic outreach and case management model used for high-risk members. The MCO provides this service centrally (financed through its capitation with the state); it is not reimbursable. The MCO refers clients requiring an in-person level of care coordination to a local CSP provider. All services coordinated through CSPECH are reimbursed through the standard mechanisms. MassHealth reimburses physical health services, using a fee-for-service arrangement; MBHP pays for health services; and funding for housing services and supports comes through various mechanisms, including U.S. Department of Housing and Urban Development (HUD) funding and state housing grant programs.

## **Goals**

CSPECH services help the state to achieve three main goals. First, following the principles of the Housing First model, CSPECH helps stabilize and improve the lives of a high-risk, high-cost population. Between 2009 and 2014, MHBP has provided CSPECH services to more than 1,250 beneficiaries. A second goal is to reduce the use of high-cost health services, such as the emergency department (ED). The CSWs work closely with CSPECH recipients once they are housed to ensure their access to needed health services. Although service use can be expected to increase in the short term as individuals are connected to needed health services, the expectation is that, over time, their use of costly emergency and crisis intervention services will decline. Finally, CSPECH is part of a broader state effort to reduce homelessness. Considering itself a “right to shelter” state, Massachusetts has diverted funding from the management of shelters toward the development of low-threshold housing and subsidies.<sup>3</sup> CSPECH services, which are available for as long as an individual remains housed, aids the state in this effort by helping clients establish life structure, learn self-management and independent living skills, and ultimately reintegrate into the community.

## **State Context**

The state’s ability to provide CSPECH services as reimbursable is the result of a policy window that appeared in the mid-2000s. In 2006, the state passed a health insurance reform law that expanded Medicaid access to include single homeless adults, encouraging MassHealth to adopt means to control health care costs for this high-cost population. The Massachusetts Housing and Shelter Alliance (MHSA), a non-profit advocacy organization that leads the state’s efforts to end homelessness, intervened to actively promote the concept behind CSPECH. MHSA partnered with MBHP to develop a service model that could easily be approved by MassHealth by structuring CSPECH in accordance with the already reimbursable CSP service. MBHP, which serves the largest proportion of MassHealth members with disabilities compared to the other state MCOs, may have felt a stronger incentive to adopt such a program. The state is in the process of implementing initiatives that aim to encourage the other MCOs to reimburse for a similar level of service.

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<sup>3</sup> Under the Housing First model, homeless individuals are moved directly into housing and offered a range of supportive services in an effort to maintain housing. The receipt of housing is not dependent on successful completion of treatment.

## ***Partnership Structure***

At the state level, CSPECH is a product of a partnership between MBHP, MHSA, and MassHealth. MassHealth does not require or directly oversee the program; rather, it is strictly a service that MBHP has opted to cover. The operational partnerships occur at the local level. CSPECH is available statewide through eight providers or provider partnerships. Three sites consist of a partnership between a community mental health center and one or more housing providers, three sites are led by a single organization that provides both behavioral health services and housing, and two sites are led by a federally qualified health center (FQHC) that has partnered with one or more local housing providers.

We visited two CSPECH providers for this review. The South Middlesex Opportunity Council (SMOC) is an antipoverty community action agency that supports and manages more than 1,700 supported housing units across the state through diverse funding sources. SMOC also supports an integrated program model that links its residents to a range of resources, including physical and behavioral health services, employment and education training, and other social benefit programs. In this model, housing support, behavioral health services, and CSPECH services all are provided through one organization.

In contrast, Eliot Community Human Services is a private, non-profit human services organization that provides homeless individuals with a range of mental health and substance abuse services, and other supportive services, but does not directly provide housing support. For this service, Eliot subcontracts with a range of other organizations that provide housing. Eliot has expanded the model by encouraging its partners, which are scattered across the state and not in MBHP's provider network, to hire their own CSWs and then submit CSW claims through Eliot. This arrangement has allowed several community housing providers (many of which also manage local shelters) to house individuals who otherwise would not have been housed due to lack of access to the supports needed to remain housed. As the manager of one shelter put it, "Without CSPECH, we'd have to find another way to support the case manager. And without having the ability to do that, these folks would have stayed in our shelter."

## **B. Coordination or Integration with Physical Health**

### ***Coordination Mechanism and Financing***

The CSW operates as the coordinator for CSPECH clients. CSW services are approved for 90 days before an individual becomes housed, allowing the CSW to work with shelter staff in identifying a potentially eligible resident. Individuals must meet the definition of being "chronically homeless," defined by HUD as an individual with a documented disability who has been continuously homeless for a year or more, or has had at least four episodes of homelessness in the previous three years. Once the client

is housed, the CSW begins to work with the client to identify service needs. CSWs maintain a caseload of about 12 clients, as required by MBHP program rules, and typically meet with each client at least once per week. CSPECH service providers are reimbursed using a fixed, flat per-day case rate, used to cover the CSW's salary.

### ***Coordinated Services and Stakeholder Interactions***

The providers of health services vary by CSPECH site; however, because all partnerships include an MBHP behavioral health provider, these services are provided through the CSPECH site partnership. With the exception of the two CSPECH sites led by an FQHC, the CSPECH partners do not provide physical health services; thus, CSWs must work with clients to identify a nearby primary care physician (PCP). CSWs often obtain a release of information from clients so PCPs can share information with them. Regardless of health service type, either MBHP or MassHealth reimburses the providers for all services. Although MBHP maintains a managed care arrangement with the state, it reimburses providers in its network on a fee-for-service basis. The low caseload allows CSWs to play an active role in coordinating service receipt, often driving and accompanying clients to appointments, and following up on referrals and prescriptions. Providers unaffiliated with the CSPECH agency, such as PCPs, have embraced CSW involvement because it often helps to ensure compliance with prescribed treatments and follow-up with suggested referrals.

## **C. Coordination or Integration with Housing or Other Social Services**

### ***Coordination Mechanism and Financing***

CSWs are trained in how to navigate both the Medicaid and housing systems, and thus are responsible for helping coordinate access to all of these services for CSPECH recipients. Housing is prioritized before other services. CSWs begin working with a client the moment a housing unit or subsidy is identified. Because CSPECH does not provide funding for housing, CSWs rely on existing and available resources within the provider network. Although the statewide supplies of affordable housing and subsidies are in high demand, CSWs are linked to organizations able to leverage and access these scarce resources. Most CSPECH provider organizations manage subsidized housing units. Because MBHP limits the number of clients a CSW can serve (roughly 12), some of the housing providers dedicate this number of units to CSPECH clients. In most cases, the units are funded with a project-based subsidy, either through HUD or state funding.

### ***Coordinated Services and Stakeholder Interactions***

In addition to helping clients find housing, CSWs work with them to maintain housing. Many clients have not lived independently for years and often struggle with community reintegration, paying utility bills, and establishing independent living skills.

CSWs, many of whom are able to connect with clients through their own lived experiences, work with clients to address these issues. Because employment may not be an option for many CSPECH clients, and due to the prevalence of ongoing substance abuse issues, CSWs focus on helping clients establish daily routines and structure, and encourage clients to volunteer in the community or enroll in a day program. To track clients, some CSPECH providers have established relationships with entities within the local criminal justice system and prison diversion programs. Finally, clients often are eligible for a range of benefits, such as Supplemental Security Income, Social Security Disability Insurance, or Supplemental Nutrition Assistance Program. CSWs help their clients navigate the complicated and often lengthy approval processes for these and other benefits.

#### **D. Key Perceptions and Lessons Learned for Implementing the Care Coordination Strategy**

**The success of the CSPECH program is rooted in the state’s willingness to embrace a Housing First model and low-threshold housing.** Many CSPECH clients are active substance users and have criminal backgrounds, preventing them from meeting the requirements associated with some HUD-funded housing programs. In 2006, the state began funding MHSAs’ Home and Healthy for Good (HHG) program, a dedicated funding source that can be used flexibly by housing and service providers as long as they are promoting low-threshold housing for chronically homeless adults. Many CSPECH clients reside in HHG-supported homes. The state also views itself as a “right to shelter” state, comparing homeless shelters to an ED--a type of triage until the individual can be moved into a more permanent living environment. The state has recognized that to successfully reduce shelter populations, housing and support services must be available.

**Program access is restrained by the supply of affordable housing and related subsidies.** Receipt of CSPECH services is limited to those who have been moved into PSH; thus, access to these services is limited to the availability of subsidized units. The state’s embrace and funding of low-threshold housing has helped address this challenge to a certain extent, yet the demand for CSPECH services remains higher than the supply of housing.

**Providers and consumers perceive that many individuals would not have housing or be able to remain in their housing in the absence of the CSPECH program.** Consumers regard the CSWs as critical to their personal success, noting that the CSW has connected them to housing, health, and social services they would not otherwise have accessed. For many consumers, the CSPECH program literally is viewed as a life saver. Providers report that the availability of CSPECH services has allowed housing developers and service providers to pursue new funding opportunities, such as HHG, more robustly; the availability of the CSPECH supports creates a market for housing a population that previously might have remained on the streets or in the shelters.

**Minimal changes in billing structures and reliance on existing provider relationships have facilitated program implementation.** CSPECH services are billed as a type of CSP service--a pre-existing service category. This arrangement has allowed for minimal billing system changes, an advantage noted by several providers in the state. MBHP's requirement that CSPECH service providers already be part of MBHP's provider network ensures a minimal need for billing-related training and assistance. (That is, these agencies must provide other Medicaid-reimbursable services.) Several CSPECH providers however, contract with organizations that do not otherwise provide Medicaid-reimbursable services, such as property management companies and homeless advocacy organizations. In these cases, a centralized billing process is used, through which the MBHP network provider submits all CSPECH reimbursement claims. These arrangements allow for expanded access to CSPECH services, as well as a stronger link between the behavioral health services and the housing resources required for CSPECH participants.

**Limitations in coverage have created service gaps.** The other state MCOs have not yet chosen to reimburse for CSPECH services, although the state is introducing an initiative that will create an incentive for them to do so. A more significant challenge occurs when a CSPECH participant becomes dually eligible for Medicaid and Medicare. Duals are not eligible for the PCC/MBHP plan. As of the writing of this report, none of the plans available for dually eligible individuals cover CSPECH services, including those that serve the state's One Care dual demonstration. Thus, upon eligibility for Medicare, a CSPECH recipient enrolled in a plan for dual-eligible beneficiaries is no longer eligible to receive these services. Housing is not lost, however, since it is not linked to the service. The providers interviewed for this review reported that, out of compassion for clients, most CSWs continue to provide service to dual-eligible clients without reimbursement, an arrangement that is not sustainable.

# UNDERSTANDING INNOVATIVE STATE SYSTEMS THAT SUPPORT COORDINATED SERVICES FOR INDIVIDUALS WITH MENTAL AND SUBSTANCE USE DISORDERS

## Reports Available

Improving the Coordination of Services for Adults with Mental Health and Substance Use Disorders: Profiles for Four State Medicaid Initiatives

HTML <http://aspe.hhs.gov/report/improving-coordination-services-adults-mental-health-and-substance-use-disorders-profiles-four-state-medicaid-initiatives>

PDF <http://aspe.hhs.gov/pdf-report/improving-coordination-services-adults-mental-health-and-substance-use-disorders-profiles-four-state-medicaid-initiatives>

Illinois Profile only -- <http://aspe.hhs.gov/pdf-report/improving-coordination-services-adults-mental-health-and-substance-use-disorders-illinois-state-profile>

Louisiana Profile only -- <http://aspe.hhs.gov/pdf-report/improving-coordination-services-adults-mental-health-and-substance-use-disorders-illinois-state-profile>

Massachusetts Profile only -- <http://aspe.hhs.gov/pdf-report/improving-coordination-services-adults-mental-health-and-substance-use-disorders-illinois-state-profile>

Tennessee Profile only -- <http://aspe.hhs.gov/pdf-report/improving-coordination-services-adults-mental-health-and-substance-use-disorders-illinois-state-profile>

State Strategies for Coordinating Medicaid Services and Housing for Adults with Behavioral Health Conditions

HTML <http://aspe.hhs.gov/basic-report/state-strategies-coordinating-medicaid-services-and-housing-adults-behavioral-health-conditions>

PDF <http://aspe.hhs.gov/pdf-report/state-strategies-coordinating-medicaid-services-and-housing-adults-behavioral-health-conditions>

State Strategies for Improving Provider Collaboration and Care Coordination for Medicaid Beneficiaries with Behavioral Health Conditions

HTML <http://aspe.hhs.gov/basic-report/state-strategies-improving-provider-collaboration-and-care-coordination-medicaid-beneficiaries-behavioral-health-conditions>

PDF <http://aspe.hhs.gov/pdf-report/state-strategies-improving-provider-collaboration-and-care-coordination-medicaid-beneficiaries-behavioral-health-conditions>