Opening Doors: National Goal to End Homelessness

The United States Interagency Council on Homelessness (USICH) authored and presented to the President and Congress in June of 2010 the nation’s first comprehensive strategy to prevent and end homelessness. Opening Doors serves as a roadmap for joint action by the 19 federal agency members of the USICH along with local and state partners in the public and private sectors. Building on a national movement to end homelessness, started by the National Alliance to End Homelessness and furthered by local ten-year plans to end homelessness, Opening Doors has set federal benchmarks to increase access to housing opportunities to the millions of Americans facing homelessness.

According to the USICH Opening Doors federal plan:

“The most successful intervention for ending chronic homelessness is permanent supportive housing, which couples permanent housing with supportive services that target the specific needs of an individual or family. There is a substantial body of literature that shows that supportive housing is successful for people with mental illness, chemical dependency, HIV/AIDS, and other often co-occurring conditions... Permanent supportive housing is designed to address these needs. Permanent supportive housing using Housing First is a proven solution that leads to improvements in health and well-being. Supportive housing also has been shown to be a cost-effective solution in communities across the country. It has been proven to be most cost-effective in places where it has been targeted to people with the most extensive needs... There is a serious shortage of permanent supportive housing across the country. This is due both to the shortage of financial resources, as well as local capacity to develop and operate supportive housing... The concentration of chronic homelessness means that the effort and focus to increase access to supportive housing must be proportional to local need.”

2 National Alliance to End Homelessness, www.endhomelessness.org
3 USICH, Opening Doors: Web. 15 July 2013:
The role of local advocates, community organizations, and public systems is to expand the supply of supportive housing to create housing opportunities for homeless families, veterans, adults, and unaccompanied youth. Medicaid reimbursable health services can assist in the delivery of supportive services to help maintain people in affordable housing.

**Affordable Care Act (Obamacare) and Expansion of Medicaid Eligibility**

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, together are referred to as the Affordable Care Act of 2010 (ACA).4 As of 2011, states have the option to expand Medicaid eligibility to include all persons who have income below 133% of poverty regardless of disability status. Therefore, the landscape for state and supportive housing programs has changed since prior to the ACA most homeless persons were not ‘categorically eligible’ for Medicaid insurance since they could not show a disability diagnosis. Supportive housing programs are now exploring ways to offer supportive services to housing participants that may be Medicaid reimbursable as a way to expand the number of supportive housing opportunities in the state.

Medicaid still has several challenges: low reimbursement rates, delayed payments, administrative hassles, and geographic access inequalities. However, it remains a major source of coverage and reimbursement for the largest percentage of the population who are under 400 percent of the federal poverty level ($80,000 for a family of four) and under 65 years of age.

**CURRENT OPPORTUNITIES**

The following is a list of current opportunities and efforts attorney’s and advocates may involve staff time in order to secure more Medicaid funding for supportive services (to expand housing opportunities):

1. **1115i Waiver to State Medicaid Plans**

Under section 1115 of the Social Security Act,5 the federal government can allow states to develop comprehensive demonstration, experimental projects that modify (waive) federal Medicaid and State Children’s Health Insurance Program (SCHIP) requirements related to benefits, cost-sharing and eligible populations.

   • Any new waivers must be “budget neutral” to the federal government. This means that federal spending can be no higher under the waiver than it would have been without the waiver.
   • Several states have combined coverage expansions with a new managed care delivery system and used the anticipated managed care savings to offset the cost of the coverage expansion.

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**Minnesota Example:**

Reform 2020 is an initiative to reform Medical Assistance (MA) — Minnesota’s Medicaid program — to better meet the challenges of rising health care costs and an aging population, while still providing Minnesotans the services they need to lead fulfilling lives. DHS held public meetings in June, July and August 2012 for clients, stakeholders and others to learn about Reform 2020 and provide comment. Staff presented an overview of Reform 2020 (PDF) and specifics on mental health, Community First Services and Supports, autism and other proposals contained in the section 1115 waiver proposal.

The Reform 2020 waiver proposal is a comprehensive package incorporating many of the key components of the overall reform initiative. On Nov. 21, 2012, DHS resubmitted the waiver proposal to the Center for Medicare and Medicaid Services (CMS). This proposal would have made the following housing stabilization services as eligible for Medicaid reimbursement up to $600 for each member per month:

- Service coordination
- Outreach/In-Reach
- Tenancy Support Services
- Community Living Assistance

The target population included: (a) Medicaid recipient who were receiving General Assistance and homeless; and (b) Medicaid recipients who were eligible of Group Residential Housing. If adopted, this demonstration could offer participants $600/month to cover community-based services (coordination, support services and community living assistance).

2. **Behavioral Health Homes**

The Affordable Care Act established the “State Option to Provide Coordinated Care through a Health Home for Individuals with Chronic Conditions”. This provision provides an opportunity to build a person-centered system of care that achieves improved outcomes for enrollees and better services and value for State Medicaid programs.

Federal statute defines health home services as comprehensive and timely high-quality services provided by a designated provider or a team of providers and specifically includes:

- comprehensive care management,
- care coordination,
- health promotion,
- comprehensive transitional care, including appropriate follow-up,
- patient and family support,
- referral to community and social support services, and
- the use of health information technology to link services.

To qualify for health home services, eligible Medicaid enrollees must meet one of three requirements:

- a serious and persistent mental illness,
- two chronic conditions, or
- one chronic condition and the risk of developing a second.
In relation to serving persons who are homeless, care management linked to affordable housing can be part of a broader health home strategy. The ACA describes three distinct types of health home provider arrangements: designated provider; team of health care professionals which links to a designated provider; or health team. Federal CMS guidance indicates that health homes do not need to provide the full array of required services themselves, but they must ensure such services are available and coordinated.

Section 2703 of the ACA sets parameters and minimum standards on the definition of health homes, the population criteria, service definitions, provider standards, provider infrastructure, payment models, quality measure reporting, and state monitoring requirements.

3. 1915i Amendment to State Medicaid Plan

Another form of Home and Community Based services, the 1915(i) option gives states the ability to provide home and community-based services to the elderly and persons with disabilities without requiring a HCBS waiver or demonstrating cost neutrality. 1915(i) allows states to cover HCBS under a Medicaid state plan option. This may be an opportunity for states to develop a more consistent strategy for financing services in PSH and a more coordinated and consistent policy framework regarding housing and services for people with disabilities and high levels of vulnerabilities who need affordable homes and long-term support. Furthermore, 1915i does not limit beneficiaries to those who need home-based services in order to avoid institutional care/treatment and can be limited geographically. A 1915i application required state legislative approval.

Iowa is the first state to receive federal approval for a HCBS state plan amendment. Iowa has set enrollment caps 3,700 people in the first year, 4,500 in the fifth year. Iowa limited services to persons with a history of mental illness. Iowa did not elect to employ a participant-directed service model.

Individuals participating in Iowa’s 1915i will be offered case management and habilitation. Habilitation services are divided in four components:

- Home-based habilitation
- Day habilitation
- Prevocational habilitation
- Supportive employment habilitation

States may consider moving forward with a 1915i proposal but will be required to obtain legislative approval to amend the State Medicaid Plan.

4. Targeted Case Management Services – Mental Health or Vulnerable Adults TCM

Targeted Case Management Services are a type of home and community-based services that assist people in gaining access to necessary care and services appropriate to the needs of an individual. Case management services are ‘targeted’ to a specific population (not state-wideness or comparability requirements). Three general areas of services reimbursed:
(1) assessment to determine services needed,
(2) development of a specific plan,
(3) referral and ‘related activities’ to help the person obtain needed services, and
(4) monitoring and follow-up.

Under TCM, federal Medicaid pays for a portion of the case management service cost and obligates a local match (a county portion) for the remaining portion of the cost. Consequently, supportive housing programs can combine TCM Medicaid funding with other sources of service funding to cover the cost of case managers.

5. Medicaid Rehabilitative Services “Rehab Option”

The Medicaid Rehabilitation Option offers rehabilitative services under the state Medicaid Plan. This is a type of “Home and Community-Based Services.” Rehab services include, “medical or remedial services recommended by a physician or other licensed practitioner... for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level.” Services can be delivered in a home or in the community and can include an array of professionals (including LCSWs, occupational therapists, psychologists, and speech pathologists). Supportive housing programs can obtain reimbursement for services intended to restore the skills tenants need to live independently and to improve functioning impaired by mental illness or chemical addiction.

Advocates have the option to work with the state to determine whether modifications can be made to assist in expanding or replicating the program elsewhere.

6. Federal Qualified Health Care Centers

Federal Qualified Health Centers were created in 1991 as a public health ‘safety net’ program to enhance the provision of primary care services in underserved urban and rural communities (Section 1861(aa) of the Social Security Act was amended by Section 4161 of the Omnibus Budget Reconciliation Act of 1990). Federally Qualified Health Centers are registered and recognized public health centers by CMS and DHS. Many FQHCs partner with grants from HHS Healthcare for the Homeless.

Medicaid reimburses FQHCs on the basis of ‘encounters’ – face-to-face interactions with clients by a licensed practitioner. FQHCs can get enhanced (cost-based) Medicaid reimbursement rates to ensure that grant dollars intended for the uninsured are available for that purpose. Medicaid reimbursement is based on the clinic’s Prospective Payment System (PPS) reimbursement rate. Direct services do not have to be delivered at the clinic (inside). Billable services are defined by federal law – FQHC’s can bill directly for professional staff but can’t bill directly for paraprofessional services. Only certain types of services are billable (one encounter per day).

FQHCs may provide a wide range of health and behavioral health services. The enhanced payment rates have made FQHC partnerships with supportive housing viable in other states. Case management services may be provided within FQHC services. Advocates suggest combing a FQHC and supportive housing by delivering: (a) on-site clinics within supportive housing structures, (b) offering home visits to clients in scattered-site locations and (c) offering clinic-based services delivered in coordination with housing programs.
Los Angeles has done quite a bit of work with partnering FQHCs with supportive housing providers. Integrating FQHCs with supportive housing programs has produced a replicable and financially sustainable model for providing services to tenants of supportive housing in California.

7. Home and Community Based Services (1915c)

Home and Community Based Services Waivers can cover support services including case management, services to transition from an institution, general goods and services, transportation, personal care and peer support. Historically, HCBS waivers have focused on elderly and developmentally disabled adults who are living or are eligible for Medicaid-financed institutional care.

While permanent supportive housing offers services to individuals with disabilities and chronic diseases, advocates are unsure as to the extent of homeless participants that may qualify for HCBA Services (i.e. people with long-term disabilities requiring Medicaid-financed institutional care). The 1915c program has generally not been afforded to adults with mental health or chemical/alcohol dependency. In most instances, the majority of their institutions costs were incurred in an IMD, which is not reimbursed by Medicaid. Therefore, it is difficult to demonstrate cost neutrality. This option has been discussed but may not be a major stream of funding toward the goal of greatly expanding PSH housing opportunities.

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