Implementation of the Affordable Care Act and Medicaid Reform in Illinois to Incorporate Permanent Supportive Housing

August 2011

This report presents steps need to be taken in policy and practice to increase the enrollment of homeless persons in Medicaid now, to recognize services delivered in permanent supportive housing as both medically necessary and preventative, to reshape the current Illinois Medicaid coverage and services to make them more streamlined and flexible, and to include PSH services as covered services under the Affordable Care Act.

Table of Contents

According to the Annual Homelessness Assessment Report (AHAR) to Congress, 38% of homeless adults have a disability. However, in Chicago, 16% currently are receiving Medicaid, and 24% receive SSI/SSDI (Chicago's 2010 HUD Application, Exhibit 1).

INTRODUCTION

Heartland Alliance, Health & Disability Advocates (HDA), and the Corporation for Supportive Housing (CSH), in collaboration with the Chicago Alliance to End Homelessness, Supportive Housing Providers Association, and the AIDS Foundation of Chicago embarked on a study of Medicaid and Permanent Supportive Housing (PSH) in Illinois to assess the current landscape of Medicaid reimbursement, eligibility, and funding in PSH and to recommend policies and practices moving forward to maximize federal and state funding for these vital services. CSH and HDA conducted a survey of PSH providers in Illinois to assess their readiness to utilize Medicaid as a source of funding for the most commonly provided services. A key finding of our study highlights that PSH providers are offering services that could be recognized by Medicaid and are serving Medicaid-eligible populations, but most are not in arrangements or do not have the infrastructure in place that allow them to receive Medicaid reimbursement. As a result, we are recommending further integration of Medicaid funding within PSH in Illinois under both the current Medicaid taxonomy and looking forward using new opportunities available under the Affordable Care Act.

This report presents steps need to be taken in policy and practice to increase the enrollment of homeless persons in Medicaid now, to recognize services delivered in permanent supportive housing as both medically necessary and preventative, to reshape the current Illinois Medicaid coverage and services to make them more streamlined and flexible, and to include PSH services as covered services under the Affordable Care Act. A critical advantage of funding PSH services in partnership with a Medicaid fiscal authority is that the state will receive a federal match for the payment of the service. The report also recommends strategies for the State to use to streamline billing and reimbursement methods in order to make it easier for PSH providers to receive Medicaid funding.

The report includes the following components:

- An overview of permanent supportive housing in Illinois.
- A current summary of Medicaid policies and plans in Illinois.
- A "cross-walk" or map of how Medicaid-eligible services align with supportive housing services.
- A summary of what options the state can select as it prepares for 2014 when health care reform is fully implemented.
- Policy and practice recommendations for actions the State and the provider community can make to improve the integration of Medicaid into permanent supportive housing now and in 2014.

The Role of Permanent Supportive Housing in

Implementing the Affordable Care Act and Medicaid Reform in Illinois

SECTION 1 - Background

Implementation of the Affordable Care Act will create a larger population of Medicaid eligible individuals as well as a larger role for community based providers to play in enrolling people in coverage, providing health care services, and coordinating care across providers and systems. It is estimated that in 2014, 800,000 new enrollees will enter the Medicaid system in Illinois joining the over 2,000,000 currently insured under Medicaid. Advance preparation on the part of both policymakers and providers can help ensure that Illinois leverages proven service models to take advantage of the funding incentives within the Act and to achieve positive health outcomes among the newly eligible population.

Permanent Supportive Housing is a Cost-Effective Coordinated Care Model

PSH encompasses a range of affordable housing models that meet the housing and services needs of persons with disabilities, both homeless and at-risk of homelessness, or who need supportive services in order to maintain housing. Services delivered in supportive housing are designed to manage mental illnesses and addictions, develop skills to maintain housing stability, coordinate other needed services, develop employment skills, and provide crisis intervention (CSH, Leveraging Medicaid 2010.) Multiple research studies have shown that permanent supportive housing is successful at improving mental health and substance abuse outcomes, improving overall health, and reducing the recurrence of homelessness. PSH is a wise investment and successful intervention in improving the lives of people who are homeless, disabled, and otherwise vulnerable; services delivered in conjunction with housing improve health and functioning, and reduce or contain costs to other public systems. Specifically, as it relates to Medicaid costs, it appears that the average cumulative costs of Medicaid-reimbursed services decreased after homeless individuals moved into supportive housing, with average per person costs of $16,932 in the two years before PSH and $12,148 in the two years after PSH (Heartland Alliance Mid-America Institute on Poverty, 2009). Other studies document more significant cost savings of housing over homelessness, and largely represent uninsured populations who use emergency rooms, inpatient hospitalizations, jails, and prisons.

Permanent Supportive Housing Currently Serves Medicaid-Eligible Populations

PSH is often targeted to persons with disabilities who comprise nearly 40% of the homeless population according to the most recent Annual Homelessness Assessment Report to Congress. However, according to the 2010 Chicago Continuum of Care Exhibit 1 only 16% of clients who exited housing were enrolled in Medicaid, creating a significant enrollment gap even under current Medicaid eligibility rules. Looking forward, in 2014, Medicaid eligibility will shift to cover all persons below 133% of poverty regardless of disability status. Therefore, the majority of persons experiencing homelessness will become eligible, changing the landscape for the State and for PSH

providers. Even in the current landscape, PSH providers often serve a Medicaid eligible population and deliver Medicaid reimbursable services, but instead rely on public and private grants to deliver the services in lieu of Medicaid. These funding areas are either stagnant or declining in Illinois at a time when PSH creation continues to grow both locally and nationally. Therefore, maximizing Medicaid reimbursement and coordinated care is the key to securing a future of stable funding for PSH providers and their clients.

Illinois has a Robus Permanent Supportive Housing Landscape

The Supportive Housing Working Group of the Illinois Affordable Housing Task Force defines Permanent Supportive Housing as follows:

> The housing and services needs of persons with disabilities and households that are homeless or at-risk of homelessness are diverse, supporting the need for a range of housing options with services available, whether on-site or community-based. While service-enriched housing models such as those serving the elderly or youth meet many needs, Permanent Supportive Housing is a unique type of affordable housing with services that has been shown to reduce homelessness. Supportive housing helps people live stable, successful lives through a combination of affordable, permanent housing and supportive services, appropriate to the needs and preferences of residents, either on-site or closely integrated with the housing. Supportive housing serves individuals and families who are homeless, at risk of homelessness, and/or have disabilities, and who require access to supportive services in order to maintain housing.

Illinois has a robust and sophisticated permanent supportive housing industry. This is the result of joint or consistent funding priorities between state and local jurisdictions in partnership with nonprofits and public-private planning bodies to create more housing with services. The primary catalyst behind the creation of supportive housing over the past decade was the emergence of 'plans to end homelessness' encouraged by the federal government, which relied heavily on the supportive housing intervention. In 2009, the first ever Federal Strategic Plan to end homelessness was released, entitled "*Opening Doors.*" Soon after the Veteran's Administration also vowed to end veteran's homelessness by 2014.

It is important to note that the development of units of permanent supportive housing typically requires that funding be obtained for services, operations, and capital. For a variety of reasons, some of which are outlined in this report, it has become increasingly difficult to obtain adequate funding for supportive services in permanent supportive housing.

Capital and Operations

According to the collective inventories of all 21 Illinois continua of care, as reported to the United States Department of Housing and Urban Development (HUD), there are 8,356 units of permanent supportive housing in Illinois for persons experiencing homelessness. Of these units, 7,119 are for individuals and 1,237 are for families. The number of units of PSH has increased by nearly 1,000 (13%) between 2005 and 2010. (Continuum of Care data aggregated by CSH.) This increase in units

has primarily been targeted to single individuals, a trend that can be attributed to the increase in federal funding for PSH for chronically homeless individuals. In particular, HUD's investment into permanent housing leasing and operations increased by 128% between 2001 and 2009.

The Illinois Housing Development Authority (IHDA) has been a strong partner in promoting the creation of PSH; IHDA prioritized PSH in its Annual Comprehensive Housing Plan and its companion annual funding application, the Qualified Action Plan. Housing developers can score higher on their applications by committing to supportive housing as well as setting aside units for supportive housing populations within the greater affordable housing development. As a result, IHDA has supported the creation of 2009 units in 68 Multi-Family Supportive Housing developments between 2003-2010. The total investment is $152,992,328 of IHDA funds leveraging another $161 million. In addition, IHDA has approved another 390 units of targeted units set aside within larger affordable housing developments for persons with disabilities, who are homeless or at-risk of homelessness, and/or persons exiting long-term care facilities.

Supportive Services

Services in supportive housing are generally funded through a mix of federal, state, and private grants, with a minority of programs receiving Medicaid reimbursement. Pressure is growing on Illinois' PSH providers to identify more stable sources of service funding as grants and general appropriations become more unpredictable and competitive.

The federal government, through HUD is the largest single funder of permanent supportive housing. HUD has increased funding for permanent supportive housing, prioritized new housing for people experiencing chronic homelessness, and evaluated local funding bodies called "continua of care" for their ability to leverage public and private funding sources. For nearly a decade, HUD has strongly encouraged its grantees to integrate "mainstream resources," which are other programs or resources that are not specifically designated for people who are homeless, but for which homeless persons likely are eligible. At the same time, HUD has shifted its funding away from supportive services, and no longer allows new housing programs to support only service activities.

A decade ago, supportive services costs accounted for the majority of the HUD budget for supportive housing. Over time, HUD policies and incentives changed the mix of how its funds were used, so that the "housing to services ratio" increased. As recently as the 2009 Homelessness Assistance Grants competition, 65.1 percent of the funds were used for Housing/Operations, 29.5 percent for services. In Chicago, for example, the local planning body passed a policy for all programs to cut service funding by 10% and also restricted the amount of service funding new applicants could request. This was in an effort to increase competiveness with HUD funding in order to receive new housing dollars, which was successful.

The Illinois' legislature has appropriated funds on an annual basis for supportive housing, which have increased to $23.6 million through FY11 and are projected to be level funded in FY12. At the same time, other grant funding for supportive services to persons with mental illness and substance abuse have decreased, with the most significant reduction in FY11 of $90 million (or 32%), which

effectively eliminated the ability for community agencies to deliver services to persons not on Medicaid. The result is mixed messages on the importance of supportive services and supportive housing, and the ability of the state to meet the needs of vulnerable populations– requiring supportive housing providers and the state to look to alternative funding sources.

The difficulty of acquiring such federal and state funds has necessitated that PSH providers in Illinois ensure that existing sources of service funding, such as Medicaid, can effectively be utilized to provide critically important services in supportive housing. This policy has also been supported through the leadership of the federal government, as outlined in "*Opening Doors*," to support the inclusion of Medicaid in the delivery of supportive housing services. The trends in funding combined with the substantial increase of eligibility and enrollment in Medicaid for almost all uninsured persons under 133% of the federal poverty level in 2014 creates an imperative for providers to begin to ready their programs to accept Medicaid recipients and to receive Medicaid reimbursement.

Select Permanent Supportive Housing Models are Leveraging Medicaid Now

The federal government is strongly encouraging states and providers to incorporate PSH services into their Medicaid programs and Affordable Care Act implementation in particular to create proactive enrollment and access strategies for people who are homeless. An analysis, completed in January 2011 by the U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation (ASPE) Office of Disability, Aging, and Long-term Care Policy entitled "Medicaid and Permanent Supportive Housing for Chronically Homeless," shows that there are existing successful models of integrating Medicaid funded services into PSH, both in the direct practice and types of waivers or fiscal authorities states can use to fund the services.

In this report we highlight examples of models that rely on coordination between multiple providers. There are other configurations of supportive housing, so the highlights below illustrate how partnerships function to integrate healthcare and housing.

One option is to have a central housing provider, with services coordinated around the tenants. An example of this model is the Community Housing Network (CHN) in Columbus, Ohio that manages over 1,000 units of scattered site housing accompanied by case management and employment services to its tenants. CHN uses its case managers to coordinate clinical services for primary and mental health as well as substance abuse services through over 40 providers. Similarly here in Illinois, ZION Community Development in Rockford manages a project-based PSH program with on-site resident service coordinators who arrange services for primary health, mental health, addiction treatment, and employment with a smaller network of service agencies.

Alternatively, a social service agency can function as the sole provider of all required services, and coordinate access to housing subsidies. In Chicago, Heartland Health Outreach (HHO) provides residential and outpatient services to people with mental illness and substance abuse disorders.

Services include primary care, dental care, psychiatric and substance abuse treatment using a harm-reduction and trauma informed modalities. HHO co-locates its services in a PSH development managed by its sister agency, Heartland Housing.

More complex models also exist that braid together even more public and private partnerships. The key components are identifying what services are needed by the population and determining how they are delivered and documented so that both the housing and services provider can deliver the maximum benefit to the residents.

The most common options to fund PSH services with Medicaid include the Medicaid Rehab Option, Home and Community-Based Services Waiver, and partnerships between PSH providers and Federally Qualified Health Centers (FQHCs). One barrier in Illinois to any of these options is a complex set of rules which often necessitate a single provider billing several agencies for services to one single client. Alternatives to this current, complicated practice could be to bundle services at a specified rate or to re-align current rules into a unified taxonomy for eligible services.

SECTION 2 – Options to Leverage Medicaid Funding for PSH Services

Through a review of the medically-necessary services provided in PSH compared with the services that can be paid for under Medicaid, and the various waivers and state plan amendments currently in use in Illinois, the following Medicaid Crosswalk was created. The Crosswalk provides a summary of the most commonly provided services in Illinois in PSH programs, referenced with the fiscal authority that is used or could be used under Medicaid to reimburse providers for providing the services to a Medicaid recipient. **The actual Crosswalk, which is a chart mapping out the various fiscal authorities and services, is in Appendix 4.**

The services that are provided in permanent supportive housing can generally be defined as case management, needs assessment/evaluation, services planning development, referral and linkage, mental health assessment/psychological evaluation, mental health treatment plan, review and evaluation, psychotropic medication administration, monitoring or training, housing search and placement, individual or group training in illness self-management; living environment, community services, and home-related skills, transportation services, substance abuse treatment, services in an employment setting. All of these services can be paid for with either regular Medicaid, or a combination of waivers and /or state plan amendments.

In the current system, providers bill for similar services under Medicaid and other State-only (General Revenue Funds (GRF)) funds. For example, case management, which is very broadly defined, is paid for by the Division of Mental Health, the Division of Alcohol and Substance Abuse, GRF funded Supportive Services under the Bureau of Homeless Services and private (foundation) funding. Only the Division of Mental Health gets Medicaid reimbursement for some of those services.

There are Medicaid fiscal authorities that also pay for employment services and supports that are not outlined above. In addition, there are Department of Labor and Rehabilitation Services Administration funds that pay for employment services for people with disabilities that can be used for tenants of supportive housing. **An Employment Crosswalk, located in Appendix 5, depicts a similar mapping of services to fiscal authority specific to these services.**

As we reflect on the significant barriers to accessing other traditional employment programs for supportive housing residents, this is another significant opportunity area to explore to improve otherwise disproportionately low employment rates.

SECTION 3 – Building the capacity of Illinois PSH Providers to leverage Medicaid

An important first step to effectively incorporate PSH services into the state's Medicaid program is to understand the extent to which current supportive housing providers across the state either bill services directly to Medicaid or utilize another billing arrangement, and under which fiscal authority. It is also important to understand the type of services delivered and the credentials of staff delivering services in PSH since that information is critical in determining what program components are a good fit for Medicaid.

In order to obtain data directly from providers of permanent supportive housing, an online survey was created. The survey was primarily designed to capture information on current services being provided and staffing patterns in use by organizations that operate supportive housing. The survey was sent to permanent supportive housing providers throughout the state and also distributed to the membership of the Supportive Housing Providers Association and the Chicago Alliance to End Homelessness. A follow-up survey was also administered to capture information not originally requested. (see Appendices 1 and 2 for the survey and follow-up survey.)

In total, 38 organizations responded to the request for survey data regarding the services that are provided in Permanent Supportive Housing (PSH). This provider group manages 52.5% of the supportive housing units in Illinois. Of these 38 respondents, 33 completed all or the majority of survey questions. For most of the calculations below, a sample size of 33 was used. Other sample sizes were utilized for some calculations based on the number of responses. The sample size (N) will be provided as a footnote. Please see Appendix 3 for complete survey results.

Organization Information and Client Demographics

The geographic areas served by the responding organizations include the City of Chicago with 42%, the Metropolitan Chicago area with 33%, and Northern, Central or Southern Illinois with 39 percent. The average number of PSH units that respondents reported having was 122 with an

average of 88 Project Based PSH Units and 60 Scattered Site Units[1]. The average number of unduplicated clients served per year is 622 and the average amount of the average reported client/household yearly income is $6,875. Client demographics are broken down by the average percentages below:

Table 1: Demographic Data (N=27)

Children age 18 or under	15.07%
Children age 18 or under in PSH	12.63%
DCFS wards	0.11%
65 and older	4.08%
Receiving SSI	42.88%
On Medicaid	46.96%
On BOTH Medicaid and Medicare	11.96%

Services Provided

In an effort to understand the services currently being provided by the survey respondents, respondents selected from a detailed list of which service(s) they provide and indicated whether these were provided directly by agency staff or through linkage agreements. The four most cited services provided directly by organizations were case management (97%), referral and linkage (85%), needs assessment (73%) and monitoring/follow-up (73%).

Staffing

Respondents selected from a detailed list of possible professional staff they employ and another list of professional staff of organizations with which they have linkage agreements. Since professionals can have multiple credentials, the responses may not reflect the number of distinct staff (e.g., Certified Alcohol Drug Counselor could also be classified as part of Case Management.) The survey responses indicate that case management staff (91%), staff with a master of social work degree (64%) and certified alcohol and drug counselors (58%) are the most common staffing categories employed directly by survey respondents. Physicians (64%) and Psychiatrists (52%) are most commonly employed through linkage agreements.

Insurance Reimbursement and Billing

Organizations were asked to provide information regarding their current reimbursement patterns both for clients who are in supportive housing and those who are not. Slightly less than half the respondents (48%) indicated that they receive Medicaid, Medicare or private insurance reimbursement for clients of their organization who do not reside in supportive housing, while 41

[1] Based on incomplete survey responses, please note that Project Based and Scattered Site Units do not match with total average PSH Units.

percent [2] indicated they received reimbursement for clients who live in supportive housing. More than half of respondents (52%) indicated that they bill under the Division of Mental Health Rule 132 and 23% indicated they are currently a provider in a managed care arrangement[3].

Service Costs

Organizations were asked to identify their average cost per unit of service for a series of services. Per fifteen minute unit of service, the highest average cost was for Crisis Intervention ($27.24) and the lowest average cost was for group training in home-related skills ($10.09). Looking at all services together, the average overall cost for a 15 minute unit of service was $16.81. See Table 2 below for the average cost for organizations that provided cost data. Please note that many organizations do not bill in this manner and have different definitions of what constitutes a unit of service. As a result, organizations do not have precise cost data broken down by unit of service in terms of a unit of time. Most staff provided an estimate based on staff salaries, which excludes other costs not measured. Therefore, the average cost data may be higher overall.

Table 2: Average cost data for services provided.

Crisis Intervention	$27.24	Training in illness self-management, Individual	$20.10
Mental Health Assessment	$22.87	Training in illness self-management, Group	$10.97
Treatment Plan Development, review, modification	$18.87	Training in living environment, Individual	$18.68
Case Management	$15.49	Training in living environment, Group	$11.17
Psychotropic Medication administration	$18.75	Training in Community Services, Individual	$18.52
Psychotropic Medication monitoring	$22.57	Training in Community Services, Group	$10.94
Psychotropic Medication training, individual	$19.66	Training in home related skills, Individual	$14.68
Oral Interpretation and Sign Language	$23.99	Training in home related skills, Group	$10.09
Needs Assessment	$12.80	Medication-related education, Individual	$17.45
Services Planning Development	$13.87	Medication-related education, Group	$11.83
Referral and Linkage	$14.06	Social Services Training in Work Environment	$23.50
Monitoring/Follow up	$14.46	Housing Search and Placement	$13.40
Evaluation	$14.20		

[2] N=32
[3] N=25

Linkage with FQHCs and Other Medical Providers

Organizations were asked to identify if they have arrangements or other affiliations with medical, mental health or substance abuse providers. More than half (58%) of agencies indicated that they had such an arrangement[4]. Of those, 23% of respondents indicated that they had an arrangement with a Federally Qualified Health Center (FQHC), while 31% indicated that they work with other agencies. Agencies were also asked whether they planned to become an FQHC and no agencies indicated that they are planning to do so.

Case Management Ratios and Contact Hours

The ratio of case managers to clients reported by organizations ranged from 2:11 to 1:50, with the most common responses clustering around 1:15 to 1:20. On average, the respondents indicated they spent at least 1 hour per week per client with more hours spent depending on individual client needs.

Assistance with Applying for Benefits

Agencies were asked if they assist clients in applying for benefits and if so how they fund this work. All respondents indicated that they assist clients with benefit applications[5]. Many respondents indicated that they consider benefits assistance to be part of normal case management and do not have funding specifically for this activity.

Substance Abuse Treatment

In a follow-up to the original survey, organizations were asked about their provision and funding of substance abuse services. Fifty-two percent (52%)[6] of responding agencies indicated that they currently provide substance treatment. Of those, approximately half (46%) fund that treatment through the Department of Alcohol and Substance Abuse (DASA).

Citizenship

In a follow-up to the original survey, organizations were asked whether they currently serve persons who are not U.S. Citizens. Forty percent (40%)[7] of organizations indicated that they do serve persons without U.S. Citizenship.

[4] N=31
[5] N=25
[6] N=25
[7] N=25

Readying Permanent Supportive Housing Providers to Partner with Medicaid Services

Medicaid is the foundation of coverage for over 45 million Americans and will become the primary payer for health care in 2014 after the largest expansion of Medicaid since its inception is implemented in the states. Illinois Medicaid is the largest insurance payer in the state and provides an economic engine in communities, hospitals, and medical centers. Although Medicaid is not without its problems – low reimbursement, delayed payments, administrative hassles, and geographic access inequalities – it still remains a major source of coverage and reimbursement for the largest percentage of the population who are under 400% of the federal poverty level (about $80,000 for a family of 4) and under 65 years of age.

Community providers including mental health, medical, and behavioral health providers, must become familiar with the intricacies of Medicaid eligibility, enrollment and reimbursement in order to play a part in the health care delivery system now and especially after 2014. In 2014, community based providers will play a larger role in health care delivery but also in health care coordination and in enrollment into health care coverage. It is estimated that in 2014, 800,000 new enrollees will enter the Medicaid system in Illinois joining the over 2,000,000 currently insured under Medicaid. Preparation before 2014 will ensure that providers are ready to play their part in enrollment, health care delivery, and coordination of care whether the reimbursement system is risk based, fee for service or, most likely, a combination thereof.

Enrolling Clients in Medicaid: Why is it important to PSH Providers and their Tenants?

At the outset, it is important to consider how PSH clients become eligible and enroll in Medicaid before 2014 and after 2014 for various reasons. (1) Illinois is generally requiring (with some exceptions) that all Department of Human Services (DHS) funded services be provided only to Medicaid-eligible individuals after July 1, 2011; (2) Illinois requires most DHS service providers to bill Medicaid so tenants must be on Medicaid in order for the provider to bill; and (3) enrolling PSH clients into Medicaid, if eligible, as soon as possible, prior to 2014 could provide the tenants with a more comprehensive package of benefits than would be available to them after 2014.

In 2014, the state will have most likely implemented its new enrollment system in development now called EVE (Eligibility, Verification and Enrollment.) This system is designed to provide a seamless enrollment system for people seeking Medicaid or insurance through the new Health Insurance Exchange that provides health insurance with a subsidy to uninsured individuals or small businesses. The EVE system will use navigators to assist people to enroll; however, community based providers such as PSH providers will be needed to help traditionally hard to serve populations enroll. In addition, PSH providers may be able to seek funding to assist populations to enroll from the state and navigator system thus bringing in needed revenue to supplement reimbursement through Medicaid.

Pre-2014: Categorical Eligibility is the Key!

In order to access Medicaid in Illinois regardless of income, a person must fit into a specific type of population. These categories are: child under age 19, parent of child under 19, pregnant women, over age 65, or disabled according to the Social Security definition of disability. If a person fits into one of these categories, only then does the state look at their citizenship/immigration status, income and assets to determine eligibility.

Most PSH tenants who are not on Medicaid have not met the SSI/SSDI definition of disability. This disability definition can be met through mental or physical impairments or a combination thereof. Substance abuse addiction does not disqualify a person from meeting the definition of disability.

Case Example: 51 year old male, no minor children, history of substance addiction (with current relapses), history of depression with some inpatient treatment, minimal outpatient treatment, minor criminal record, no significant work history in the past 10 years, no high school degree or GED, 11th grade last completed, high blood pressure, diabetes and back pain from old injury. With advocacy, this client may be eligible for SSI/SSDI.

These clients generally need case management and advocacy to build the case for SSI and Medicaid. The client needs to file an application and appeal it if denied; get current treatment records if available; obtain a psychological evaluation, and order medical records. All homeless services and supportive housing providers are encouraged to use the SSI Outreach and Access to Recovery (SOAR) model for SSI enrollment. SOAR is a national model supported by the U.S. Department of Health and Human Services (HHS), and in 2010 Illinois became recognized as a "SOAR State." This means that the Bureau of Disability Determination Services and Social Security offices have agreed to process applications using the SOAR workflow.

Post-2014 No Need to Meet Categorical Eligibility!

For the first time, non-categorical adults will be eligible for Medicaid in 2014 if their income is below 133% FPL. Illinois has over 800,000 adults who currently do not meet any Medicaid eligibility category but will be eligible for Medicaid in 2014 due to their income.

We do not know what the enrollment or eligibility process will be in 2014 for this new population. We know that in aside from meeting the income threshold, there is no asset determination. As of current rules, they will have to document their citizenship and identity through original birth certificates and state identification cards. They also will have to document their income through tax returns, bank statements, and/or employment.

Practice Recommendations for PSH Providers to Get Ready for 2014 - Enrollment

1. Homeless services and supportive housing providers should identify clients who have potential or pending SSI claims and connect them with SOAR trained case managers or legal representatives to apply for SSI and Medicaid for their clients. The State should fund the SOAR project to increase the ability of organizations to assist clients with applications.

2. Homeless services and supportive housing providers should begin to collect identity and citizenship documentation for clients in anticipation of enrollment in Medicaid in 2014.

3. Homeless services and supportive housing providers should be paid to enroll people in Medicaid as the State has done with the All Kids program.

Becoming a Medicaid Provider and Receiving Medicaid Reimbursement

The following information describes how organizations become a Medicaid provider, but is not a recommendation that all or most agencies pursue this path. However it is important to know the current system of how the state partners with organizations to deliver Medicaid-billable services and how this function changes or stays the same in the future.

The Medicaid program is administered by the Illinois Department of HealthCare and Family Services (HFS), a state agency which enrolls providers such as physicians and nurses in the Medicaid programs. There are different licensure requirements based upon provider type and the population served. In order to receive Medicaid reimbursement as a medical provider, you must enroll as a provider with HFS even if you are receiving reimbursement through a managed care organization.

The Illinois Department of Human Services enrolls other types of Medicaid providers including Alcohol and Substance Abuse providers and Mental Health Providers. Each of these provider types has their own requirements and certifications that are necessary in order to receive reimbursement. However, PSH providers may receive reimbursement from Medicaid through a DHS program by billing through a third party provider such as a Federally Qualified Health Center (FQHC), another Medicaid provider, or other linkage agreements. The enrollment procedures are listed here: http://www.dhs.state.il.us/page.aspx?item=32255

The current methods of reimbursement under Medicaid as well as the delivery system will most likely change by 2014. Illinois passed a law last year to require that at least 50% of all Medicaid recipients receive their health care through a risk based coordinated care plan by 2014. This means that most Medicaid recipients will be enrolled in some managed care plan by 2014. For providers such as PSH providers, it may be necessary to be an enrolled provider in a managed care entity (which could be a Health Maintenance Organization or another type of entity) or in several managed care entities by 2014 in order to serve Medicaid recipients.

The current structure of the delivery system under Medicaid is also expected to change by 2014. There will most likely be a combination of coordinated care plans such as HMOs available to Medicaid recipients but there will also likely be other more community based behavioral health systems developed to serve the most vulnerable populations such as the homeless. One of these new coordinated care systems is called the Health Home Option. In a Health Home Option, which Illinois is currently looking into developing, a coordinated network of health providers including behavioral health and medical providers create a health home to deliver services to an individual in a more coordinated manner. PSH providers will most likely participate in Health Homes if they can

provide the full array of behavioral, social, medical and case management services or link with other providers to do so.

The Role of PSH Providers in a Coordinated Care System

As we look toward 2014 and the implementation of health care reform, the state is reconfiguring the Medicaid program to integrate the eligibility and enrollment system with the new health care exchange system. The Health Care Exchange will be a public system that offers individual and small group health insurance products at a subsidized price for people under 400% of the Federal Poverty Level with no regard to their pre-existing health conditions or health status. This exchange will replace the current temporary health insurance high risk pools that exist in Illinois – the ICHIP (Illinois Comprehensive Health Insurance) and IPXP (Illinois Pre-Existing Health Insurance) programs.

As mentioned earlier, parallel efforts are continuing to create a universal enrollment system for Medicaid and the Exchange and to create a more integrated delivery system for Medicaid, called EVE. The state has contracted with a consultant to determine whether the EVE system will be built on the base of an existing HFS or DHS system or will be developed independently. It must be a system that can verify eligibility information electronically and income information from the Internal Revenue Service according to the mandate of the Affordable Care Act. The system also must use a navigator to assist enrollees in choosing or being placed into benefit plans. For most Medicaid recipients, which benefits are covered is determined by federal and state law; however, they may have a choice of medical home or managed care provider.

The state is also embarking now on a series of reforms to the Medicaid delivery system including the Integrated Care Management Program with Aetna and Illinicare (a managed care pilot for 40,000 Medicaid recipients in Cook and the Collar Counties excluding the City of Chicago beginning June 2011.) The state is also planning to issue more Requests for Proposals for coordinated care plans for segments of the Medicaid population with an emphasis on disease management. There are also new Medicaid coordinated care opportunities available in the ACA, such as Health Home Options, which allow the state to receive more federal funding to coordinate care for special Medicaid populations with chronic conditions such as mental illness, obesity, diabetes and HIV. The trend toward 2014 is a delivery system for Medicaid that is less fragmented and dependent upon fee for service providers. The state is looking toward more integrated care and risk based management of services.

Practice Recommendations for PSH Providers to Get Ready for 2014 – Service Systems

1. The advisory group should encourage their organizations to provide comments on the proposed HFS/DHS Eligibility Verification and Enrollment (EVE) System. The EVE should include linkages with the HMIS data throughout the State.

2. Have trainings to educate providers about conceptualizing the delivery of these services as health care services and about health care reform and their role in the new health care delivery system.

Fostering Partnerships between PSH and Entities that Bill Medicaid in Illinois

It is currently possible for PSH programs to link with healthcare and mental health providers that have the ability to access Medicaid funding for those who are already insured or eligible to be insured by Medicaid. It is also important to have an understanding of where the uninsured are in our state, project how many in each local jurisdiction will become eligible in 2014, and identify what service resources exist to help the population. In an effort to understand the geographic relationship between PSH, Federally Qualified Health Centers (FQHCs), Community Mental Health Centers (CMHCs), and the uninsured, we created a map which can be accessed here or in Appendix 7. The map includes 548 FQHC and FQHC "Look-alikes"[8] and 198 CMHCs that are spread across 102 counties and 21 Continua of Care (CoCs) jurisdictions. There are 52 counties with no FQHC or Look-alike, but many of those counties are located within large continuum of care areas that contain relatively few units of permanent supportive housing and have FQHC's in neighboring counties within the same CoC. This includes northwestern and southwestern parts of the state, and an isolated county in eastern Illinois.

There are twelve counties where more than 40 percent of the population that is below 138 percent of the federal poverty level is uninsured. While some of these counties do not currently have high rates of homelessness, the needs and capacity of the areas to serve the currently and newly eligible households, including the homeless and vulnerable may warrant special attention moving toward 2014.

SECTION 4 - Recommendations for Illinois to Leverage Medicaid for PSH Services

Based on the analysis of the Medicaid Crosswalk and results of the PSH Provider Survey, the following recommendations aim at preparing the state to leverage the benefits of integrating Medicaid and PSH services.

1. The State should review the taxonomy of GRF funded PSH services provided through the Bureau of Supportive Housing, Rule 132 mental health services (MRO), and approved Rule 2090/2060 DASA services to re-define into categories of similar services and streamline billing for providers, while maintaining current funding for those individuals not eligible for Medicaid and services that are not allowable for Medicaid. *This recommendation is in line with the State's Cross-Agency Medicaid Commission that has*

[8] An FQHC "Look-alike" is a Federally Qualified Health Center that does not receive Section 330 funding, but in all other respects is treated as an FQHC.

recommended the State "[E]xpand claims eligible for FFP on mental health services and foster care expenses through certified providers."

2. The State should encourage new partnerships between providers with other PSH providers and with health homes such as CMHCs, community mental health boards (708 boards) and Federally Qualified Health Centers to better integrate service delivery and billing.

3. The State should provide more flexibility in the DASA Rule 2090/2060 licensure and services to allow a hybrid of level 1 outpatient services to be provided in permanent supportive housing and revise the licensing requirements needed. (Note: Current Level I outpatient services require at minimum 9 hours of services offered; Level III residential require at minimum 25 hours of services per week.)

4. The State should review current reimbursement strategies such as Medicaid Rehabilitative Option (Rule 132) to maximize Medicaid matching funds. *This recommendation is in line with the State's Cross-Agency Medicaid Commission that recommends that State "[E]xplore strategies to maximize billing for currently certified providers" and "[M]aximize FFP through DHS' Division of Mental Health."*

4. The State should explore expanded braided funding opportunities through Vocational Rehabilitation and the Medicaid fiscal authorities for supported employment and other employment services. *This recommendation is in line with the State's Cross-Agency Medicaid Commission that the State "[A]llow for claiming on bundled services at a rate that is comparable to what is being paid for residential care."*

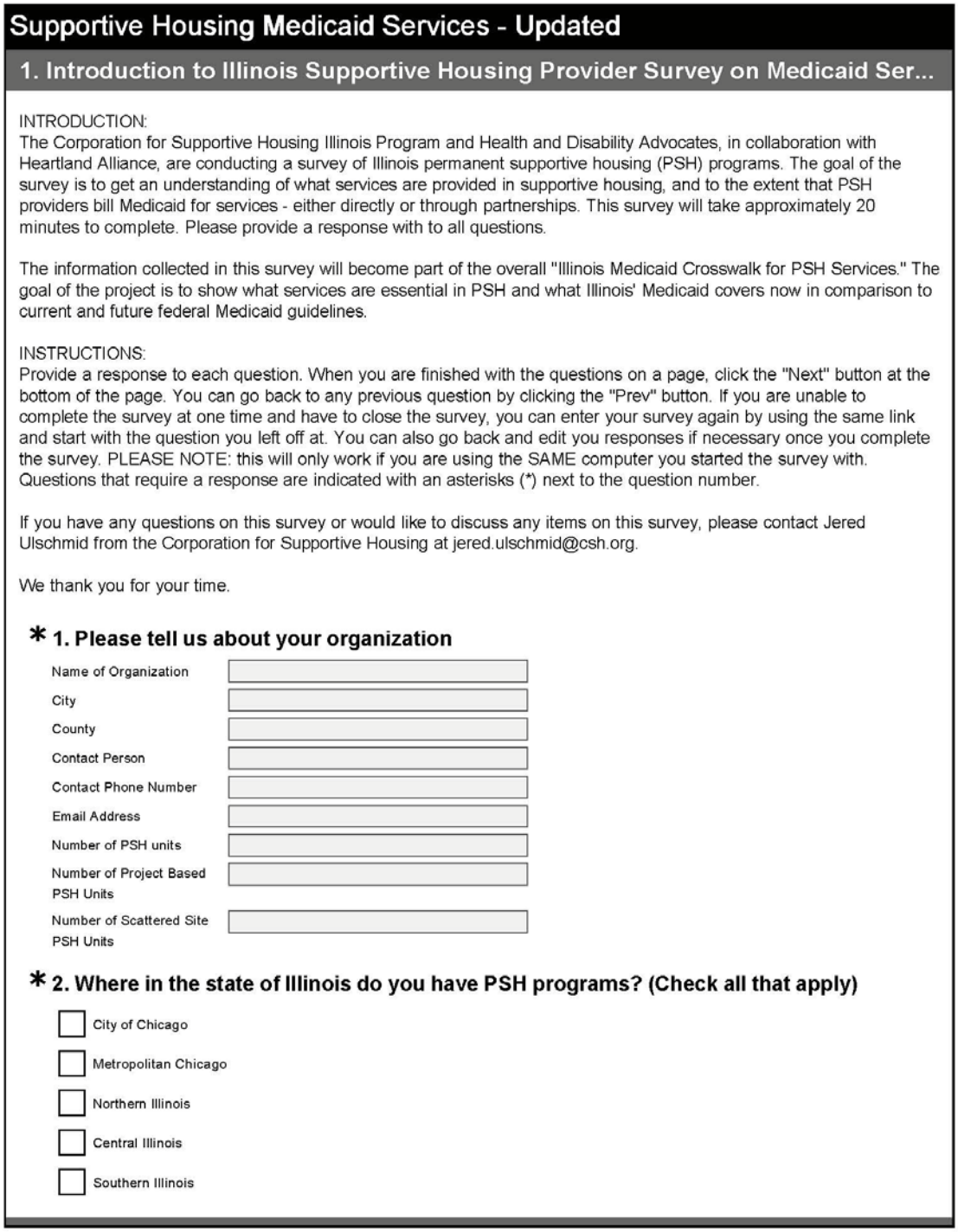
5. The state should analyze the cost-effectiveness of new opportunities under the Affordable Care Act and existing but underutilized fiscal authorities such as:

    a. Targeted Case Management
    b. Health Home Option
    c. 1915i
    d. 1915k Community First Choice Option
    e. DRA Benchmark Package to Expand to Include Case Management
    f. Bundled Payment Methodologies –Any rules or legislation guiding development of mechanisms concerning residential programming, be it funding or operational (i.e. SB1623) should include provider, consumer and advocate representation on bodies where policy or rules are defined. This recommendation is in line with the State's Cross-Agency Medicaid Commission that the State "[A]llow for claiming on bundled services at a rate that is comparable to what is being paid for residential care."

Conclusion

We hope that this report assists PSH providers and the State in their planning and implementation of health care reform. In particular, we urge the State and providers to take advantage of all Medicaid fiscal authorities that could maximize federal reimbursement for supportive services funding. We also hope the State will include PSH providers in any coordinated care delivery as vital and efficient providers of health care to persons experiencing homelessness.

Appendix 1: Illinois Supportive Housing Provider Survey on Medicaid Services



Supportive Housing Medicaid Services - Updated

1. Introduction to Illinois Supportive Housing Provider Survey on Medicaid Ser...

INTRODUCTION:
The Corporation for Supportive Housing Illinois Program and Health and Disability Advocates, in collaboration with Heartland Alliance, are conducting a survey of Illinois permanent supportive housing (PSH) programs. The goal of the survey is to get an understanding of what services are provided in supportive housing, and to the extent that PSH providers bill Medicaid for services - either directly or through partnerships. This survey will take approximately 20 minutes to complete. Please provide a response with to all questions.

The information collected in this survey will become part of the overall "Illinois Medicaid Crosswalk for PSH Services." The goal of the project is to show what services are essential in PSH and what Illinois' Medicaid covers now in comparison to current and future federal Medicaid guidelines.

INSTRUCTIONS:
Provide a response to each question. When you are finished with the questions on a page, click the "Next" button at the bottom of the page. You can go back to any previous question by clicking the "Prev" button. If you are unable to complete the survey at one time and have to close the survey, you can enter your survey again by using the same link and start with the question you left off at. You can also go back and edit you responses if necessary once you complete the survey. PLEASE NOTE: this will only work if you are using the SAME computer you started the survey with. Questions that require a response are indicated with an asterisks (*) next to the question number.

If you have any questions on this survey or would like to discuss any items on this survey, please contact Jered Ulschmid from the Corporation for Supportive Housing at jered.ulschmid@csh.org.

We thank you for your time.

* 1. Please tell us about your organization

Name of Organization
City
County
Contact Person
Contact Phone Number
Email Address
Number of PSH units
Number of Project Based PSH Units
Number of Scattered Site PSH Units

* 2. Where in the state of Illinois do you have PSH programs? (Check all that apply)

- [ ] City of Chicago
- [ ] Metropolitan Chicago
- [ ] Northern Illinois
- [ ] Central Illinois
- [ ] Southern Illinois

Page 1

Supportive Housing Medicaid Services - Updated

2. Professional Staff

*** 3. Do you employ any of the following professional staff? (Check all that apply)**

- [ ] Physician
- [ ] Psychiatrist
- [ ] Psychologist
- [ ] Master of Social Work (MSW)
- [ ] Licensed Clinical Social Worker (LCSW)
- [ ] Licensed Clinical Professional Counselor
- [ ] Nursing Degree - RN
- [ ] Nursing Degree- APN
- [ ] Case Management
- [ ] Certified Alcohol Drug Counselor (CADC)
- [ ] Vocational Rehabilitation (VR)
- [ ] Peer counselor
- [ ] None of the above
- [ ] Other (please specify)

3. Linkage Agreements With Professional Staff

Supportive Housing Medicaid Services - Updated

*** 4. Do you have any linkage agreements or other arrangements with organizations or providers who employ the following professional staff? (Check all that apply)**

- [ ] Physician
- [ ] Psychiatrist
- [ ] Psychologist
- [ ] Master of Social Work (MSW)
- [ ] Licensed Clinical Social Worker (LCSW)
- [ ] Licensed Clinical Professional Counselor
- [ ] Nursing Degree - RN
- [ ] Nursing Degree- APN
- [ ] Case Management
- [ ] Certified Alcohol Drug Counselor (CADC)
- [ ] Vocational Rehabilitation (VR)
- [ ] Peer counselor
- [ ] None of the above
- [ ] Other (please specify)

4. Services Provided

Supportive Housing Medicaid Services - Updated

*** 5. What are the main services that you provide? (Check all that apply)**

- [ ] Crisis Intervention
- [ ] Mental Health Assessment
- [ ] Treatment Plan Development, review, modification
- [ ] Case Management
- [ ] Psychotropic Medication administration
- [ ] Psychotropic Medication monitoring
- [ ] Psychotropic Medication training, individual
- [ ] Oral Interpretation and Sign Language
- [ ] Needs Assessment
- [ ] Services Planning Development
- [ ] Referral and Linkage
- [ ] Monitoring/Follow up
- [ ] Evaluation
- [ ] Training in illness self-management, Individual
- [ ] Training in illness self-management, Group
- [ ] Training in living environment, Individual
- [ ] Training in living environment, Group
- [ ] Training in Community Services, Individual
- [ ] Training in Community Services, Group
- [ ] Training in home related skills, Individual
- [ ] Training in home related skills, Group
- [ ] Medication-related education, Individual
- [ ] Medication-related education, Group
- [ ] Social Services Training in Work Environment
- [ ] Housing Search and Placement
- [ ] Other (please specify)

Page 4

Supportive Housing Medicaid Services - Updated

*** 6. For each service that you selected from Question #5 above, please provide the average cost per unit of service AND state what is defined as a "unit of service" (e.g., $30 for 15 minute increment). If none or not applicable, enter N/A or leave blank.**

Crisis Intervention	
Mental Health Assessment	
Treatment Plan Development, review, modification	
Case Management	
Psychotropic Medication administration	
Psychotropic Medication monitoring	
Psychotropic Medication training, individual	
Oral Interpretation and Sign Language	
Needs Assessment	
Services Planning Development	
Referral and Linkage	
Monitoring/Follow up	
Evaluation	
Training in illness self-management, Individual	
Training in illness self-management, Group	
Training in living environment, Individual	
Training in living environment, Group	
Training in Community Services, Individual	
Training in Community Services, Group	
Training in home related skills, Individual	
Training in home related skills, Group	
Medication-related education, Individual	
Medication-related education, Group	
Social Services Training in Work Environment	
Housing Search and Placement	

Supportive Housing Medicaid Services - Updated

Other

5. Client Demographics

*** 7. Please provide your client demographics for the following (indicate none with 0 (zero)):**

Unduplicated clients served per year

Average client/household yearly income

Percent of clients who are children age 18 or under

Percent of clients who are children age 18 or under in PSH

Percent of clients who are DCFS wards

Percent of clients age 65 and older

Percent of clients receiving SSI

Percent of clients on Medicaid

Percent of clients on BOTH Medicaid and Medicare

6. Medicaid

*** 8. Do you receive any reimbursement from Medicaid, Medicare, private insurance or any other payor for services that you provide to the supportive housing clients?**

- ◯ Yes
- ◯ No
- ◯ Don't Know

If yes, who do you bill? Medicaid, Medicare, private Insurance, other. If no, why not?

Supportive Housing Medicaid Services - Updated

*** 9. Do you receive any reimbursement from Medicaid, Medicare, private insurance or any other payor for services that you provide to clients NOT in supportive housing? If yes, who do you bill? Medicaid, Medicare, private Insurance, other? If no, why not?**

- ◯ Yes
- ◯ No
- ◯ Don't Know

If yes, who do you bill? Medicaid, Medicare, private Insurance, other? If no, why not?

*** 10. Under what "rule" or state certification do you bill a third-party payor? (Check all that apply)**

- ☐ DASA 2060
- ☐ Rule 132
- ☐ FQHC (Federally Qualified Health Center)
- ☐ Children
- ☐ Seniors
- ☐ Unknown
- ☐ Other (please specify)

*** 11. Are you a provider in any managed care arrangements such as an HMO?**

- ◯ Yes
- ◯ No
- ◯ Don't Know

If yes, please list the name of the network

Supportive Housing Medicaid Services - Updated

*** 12. Do you keep any cost or expenditure data per service? If yes, what data do you have?**

- ◯ Yes
- ◯ No
- ◯ Don't Know

If Yes, plese specify data

*** 13. Do you have any arrangement, contract, affiliation or on-site arrangement with a medical, (including a Federally Qualified Health Center) mental health, substance abuse, or any other type of provider? If yes, please state the rule under which the party bills for services (if known), or provide other comments**

- ◯ Yes
- ◯ No
- ◯ Don't Know

If yes, please state the rule under which the party bills for services (if known), or provide other comments

7. Additional Questions

*** 14. On average, what is the current ratio of case managers to clients? (e.g., 1 case manager to 15 clients or 1:15)**

15. About how many contact hours does your agency provide per person per case manager?

*** 16. Does your agency plan to become an FQHC (Federally Qualified Health Center)?**

- ◯ Yes
- ◯ No
- ◯ Don't Know
- ◯ Agency already is an FQHC

Supportive Housing Medicaid Services - Updated

*** 17. Do you assist clients in applying for benefits (e.g., SSI, food stamps, unemployment, etc.)? If yes, how do you fund this?**

- ◯ Yes
- ◯ No
- ◯ Don't Know

If yes, how do you fund this?

*** 18. Does the agency provide substance abuse treatment to clients?**

- ◯ Yes
- ◯ No
- ◯ Don't Know

8. DASA Funding

*** 19. How do you fund your organization's substance abuse treatment?**

- ◯ Department of Alcohol and Substance Abuse (DASA)
- ◯ Don't Know
- ◯ Other (please specify)

9. Serving Other Vulnerable Populations

20. Do you currently serve persons who are not U.S. Citizens?

- ◯ Yes
- ◯ No
- ◯ Don't Know
- ◯ Choose Not to Answer

If yes, approximately what percent of your clients are not U.S. Citizens?

10. Thank you!

Thank you for completing this survey. Your responses will be used to inform statewide stakeholders and develop

Page 9

recommendations for expansion of Medicaid coverage to include services in supportive housing.

If you have any questions about this survey contact Jered Ulschmid from the Corporation for Supportive Housing at jered.ulschmid@csh.org or if you have specific questions about how the the survey will be used, please contact Stephanie Hartshorn at stephanie.hartshorn@csh.org

Thank you!

Appendix 2: Illinois Supportive Housing Provider Follow-Up Survey on Medicaid Services

Supportive Housing Medicaid Services - Follow-up

1. Follow-up to Illinois Supportive Housing Provider Survey on Medicaid Servic...

FOLLOWING UP:
Thank you for participating in the Supportive Housing Provider Survey on Medicaid Services! Based on responses from agencies and feedback from a Medicaid and supportive housing advisory meeting, we have identified that some more information is needed from supportive housing providers. Therefore, we are looking for your cooperation again to provided us with critical information by answering a few more questions.

INSTRUCTIONS:
Provide a response to each question. When you are finished with the questions on a page, click the "Next" button at the bottom of the page. You can go back to any previous question by clicking the "Prev" button. If you are unable to complete the survey at one time and have to close the survey, you can enter your survey again by using the same link and start with the question you left off at. You can also go back and edit you responses if necessary once you complete the survey. PLEASE NOTE: this will only work if you are using the SAME computer you started the survey with. Questions that require a response are indicated with an asterisks (*) next to the question number.

If you have any questions on this survey or would like to discuss any items on this survey, please contact Jered Ulschmid from the Corporation for Supportive Housing at jered.ulschmid@csh.org.

We thank you for your time.

BACKGROUND OF SURVEY:
As with the first survey, the Corporation for Supportive Housing Illinois Program and Health and Disability Advocates, in collaboration with Heartland Alliance, are conducting a survey of Illinois permanent supportive housing (PSH) programs. The goal of the survey is to get an understanding of what services are provided in supportive housing, and to the extent that PSH providers bill Medicaid for services - either directly or through partnerships. This survey will take approximately 10 minutes to complete.

The information collected in this survey will become part of the overall "Illinois Medicaid Crosswalk for PSH Services." The goal of the project is to show what services are essential in PSH and what Illinois' Medicaid covers now in comparison to current and future federal Medicaid guidelines.

*** 1. Please tell us about your organization**

Name of Organization	
City	
County	
Contact Person	
Contact Phone Number	
Email Address	
Number of PSH units	
Number of Project Based PSH Units	
Number of Scattered Site PSH Units	

2. Services Provided and Average Cost Per Unit of Service

Supportive Housing Medicaid Services - Follow-up

*** 2. For each service that your organization provides below, please provide the average cost per unit of service AND state what is defined as a "unit of service" (e.g., $30 for 15 minute increment). If none or not applicable, enter N/A or leave blank.**

Crisis Intervention	
Mental Health Assessment	
Treatment Plan Development, review, modification	
Case Management	
Psychotropic Medication administration	
Psychotropic Medication monitoring	
Psychotropic Medication training, individual	
Oral Interpretation and Sign Language	
Needs Assessment	
Services Planning Development	
Referral and Linkage	
Monitoring/Follow up	
Evaluation	
Training in illness self-management, Individual	
Training in illness self-management, Group	
Training in living environment, Individual	
Training in living environment, Group	
Training in Community Services, Individual	
Training in Community Services, Group	
Training in home related skills, Individual	
Training in home related skills, Group	
Medication-related education, Individual	
Medication-related education, Group	
Social Services Training in Work Environment	
Housing Search and Placement	
Other	

Supportive Housing Medicaid Services - Follow-up

3. Additional Questions

* **3. On average, what is the current ratio of case managers to clients? (e.g., 1 case manager to 15 clients or 1:15)**

4. About how many contact hours does your agency provide per person per case manager?

* **5. Does your agency plan to become an FQHC (Federally Qualified Health Center)?**

- ◯ Yes
- ◯ No
- ◯ Don't Know
- ◯ Agency already is an FQHC

* **6. Do you assist clients in applying for benefits (e.g., SSI, food stamps, unemployment, etc.)? If yes, how do you fund this?**

- ◯ Yes
- ◯ No
- ◯ Don't Know

If yes, how do you fund this?

* **7. Does the agency provide substance abuse treatment to clients?**

- ◯ Yes
- ◯ No
- ◯ Don't Know

4. DASA Funding

Supportive Housing Medicaid Services - Follow-up

*** 8. How do you fund your organization's substance abuse treatment?**

- ◯ Department of Alcohol and Substance Abuse (DASA)
- ◯ Don't Know
- ◯ Other (please specify)

5. Serving Other Vulnerable Populations

9. Do you currently serve persons who are not U.S. Citizens?

- ◯ Yes
- ◯ No
- ◯ Don't Know
- ◯ Choose Not to Answer

If yes, approximately what percent of your clients are not U.S. Citizens?

6. Thank you!

Thank you for completing this survey. Your responses will be used to inform statewide stakeholders and develop recommendations for expansion of Medicaid coverage to include services in supportive housing.

If you have any questions about this survey contact Jered Ulschmid from the Corporation for Supportive Housing at jered.ulschmid@csh.org or if you have specific questions about how the the survey will be used, please contact Stephanie Hartshorn at stephanie.hartshorn@csh.org

Thank you!

Appendix 3: Glossary Quickview

Targeted Case Management

Authority: State Plan Option under 42 CFR 441.18 and 42 CFR 440.169
Eligibility: Medicaid eligible; Freedom of Choice applies so all willing providers must be allowed to participate but can target to qualified providers by setting certain qualifications; may target to certain populations, such as homeless populations, or geographic areas of the state.
Services: Services that assist individuals "eligible under the state plan who reside in a community setting or are transitioning to a community setting" in gaining access to needed medical, social, educational and other services." Prohibits TCM for individuals transitioning into community settings from institutions for mental diseases (IMDs). Specifies TCM activities as specified procedures (taking client history, identifying the individual's needs, and gathering documents and information to form a complete assessment); development and periodic revision of a specified care plan; referral and related activities; and monitoring and follow-up activities to assure that services are performed as specified in the care plan or performed as part of a comprehensive assessment and periodic reassessment of the need for medical, educational, social or other services. Requires that states indicate in their plan that "case management services. . . will not duplicate payments made to public agencies or private entities under the state plan and other program authorities."

1915i

Authority: State Plan Option.
Eligibility: May cover people who have incomes up to 300% of the SSI amount if they meet the need for home and community based services criteria; must cover people with incomes under 150% FPL even if do not meet HCBS criteria (able to reach people before need institutional level of care); no cap on enrollment; must be offered statewide.
Services: expanded breadth of services that can be provided for a targeted population such as people with mental illness.

1915k

Authority: State Plan Option with additional Federal Financial Participation of 6% for optional services.
Eligibility: Must cover individuals who are Medicaid eligible up to 150% FPL unless state uses higher income level for those who meet HCBS criteria; must meet HCBS institutional need; no cap or targeting allowed.
Services: optional services that are more transition related such as employment, rental assistance; ADL training can be covered. This is an expansive state plan option to cover long term care services and supports for a broad cross-disability population.

DRA 1937 Benchmark Plan

Authority: State Plan.
Eligibility: Under 150% FPL or income eligibility at time of enactment; do not have to meet institutional level of care if services are needed to maintain functional status; do not need to meet

statewideness or comparability so populations can be targeted and services can be wrapped around existing populations.
Services: Case management, homemaker/home health aide services, personal care, adult day health, habilitation, respite care, day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services for individuals with chronic mental illness.

Health Home State Plan Option
Authority: ACA, State Plan Option, SMD Letter.
Eligibility: Medicaid eligible; two chronic conditions or severe mental illness; state may receive 90% FFP for broad based care coordination services including medical home component; nine quarters of enhanced funding only but state may have multiple Health Homes. Can be combined with other waivers or state plan options. Can be coordinated with Money Follows the Person.

Appendix 4: Medicaid Crosswalk

Selected Key Medicaid Fiscal Authorities for Supportive Housing Services

Major Categories of Permanent Supportive Housing Services in Illinois	General Medicaid Service Description	Medicaid Rehab Option – State Plan 1905 (a) (13)	TCM -- State Plan 1905 (a)	1915 (i) HCBS Option	1915 (k) Comm. First Choice Option	Section 1915 (b) (3) Managed Care	Section 1915 (c) Managed Care	Health Home State Plan Option	Federally Qualified Health Center
Case Management (Rule 132 and PSH)	Targeted Case Mgmt or Community Supports		X	X	X	X	X	X	X
Needs Assessment/Evaluation (Rule 132 and PSH)	Assessment; Case Mgmt	X	X	X	X	X	X	X	X
Services Planning Development (Rule 132 and PSH)	Assessment and Targeted Case Mgmt	X	X	X	X	X	X	X	X
Referral and Linkage (Rule 132 and PSH)	Community Support; Targeted Case Mgmt		X	X	X	X	X	X	X
Crisis Intervention (Rule 132)	Clinic Based or Mobile Crisis	X	X	X	X	X	X	X	X
Mental Health Assessment/Psychological Evaluation (Rule 132)	Assessment	X		X	X	X	X		X
Mental Health Treatment Plan, Review and Modification (Rule 132)	Assessment and Treatment Plan	X		X	X	X	X		X
Psychotropic Medication Administration, Monitoring or Training (Rule 132)	Community Support or Independent Living Skills	X		X	X	X	X		X
Housing Search and Placement (PSH, MFP)	Referral and Linkage		X	X	X			X	

Individual or Group Training in illness self-management; living environment; Community Services; and home related skills. (PSH)	Community Supports; Independent Living Skills Training; Homemaker	X			X	X			X	X
Transportation Services (PSH)	Emergency or non-emergency	X	X		X	X	X	X	X	X
Substance Abuse Treatment (DASA Rule 2060/2090)	Outpatient Clinical Services; Counseling	X			X	X	X	X		
Services in an Employment Setting (PSH)	*See Separate Employment Supports Chart									

"Rule 132": Department of Mental Health Rule 132: Mental Health Services (GRF/Medicaid)

"PSH": Permanent Supportive Housing Services Generally Funded Under Permanent Supportive Housing Line Item through General Revenue Fund (GRF)

"DASA Rule 2060/2090" : Division of Alcohol and Substance Abuse Services (GRF/Medicaid)

"MFP": Money Follows the Person (Medicaid)

"MRO": Medicaid Rehabilitation Option (Medicaid)

"HCBS": Home and Community Based Services (Medicaid)

"TCM": Targeted Case Management

Appendix 5: Employment Crosswalk

HDA MEDICAID FISCAL AUTHORITIES FOR EMPLOYMENT FUNCTIONS/SERVICES

Employment Functions/Services	**Possible Medicaid Service Category**	Rehab Option – State Plan 1905 (a) (13)	TCM -- State Plan 1905 (a)	1915 (i) – State Plan	1915 (k) – State Plan	Section 1915 (b) (3)	Section 1915 (c)	DRA Benchmark Plans – 1937
Education & Outreach on Employment programs	Individual Counseling; Community Support		✓	✓	✓		✓	✓
Information & Referral to ENs, VR other employment supports & resources	Community Support or Targeted Case Management	✓	✓	✓	✓	✓	✓	✓
Employment planning/Work Incentives Analysis	Targeted Case Management; Community Support; Individual Counseling	✓	✓	✓	✓	✓	✓	✓
Customized Benefits Planning & Counseling	Targeted Case Management; Community Support; Individual Counseling	✓	✓	✓	✓	✓	✓	✓
On-going Benefits Management	Community Support or Independent Living Skills		✓	✓	✓	✓	✓	✓
Individual Employment Plan service/goal setting	Community Support; Targeted Case Management; Individual Counseling	✓	✓	✓	✓	✓	✓	✓
Providing advisement on health insurance	Community Support; Targeted Case	✓	✓	✓	✓	✓	✓	✓

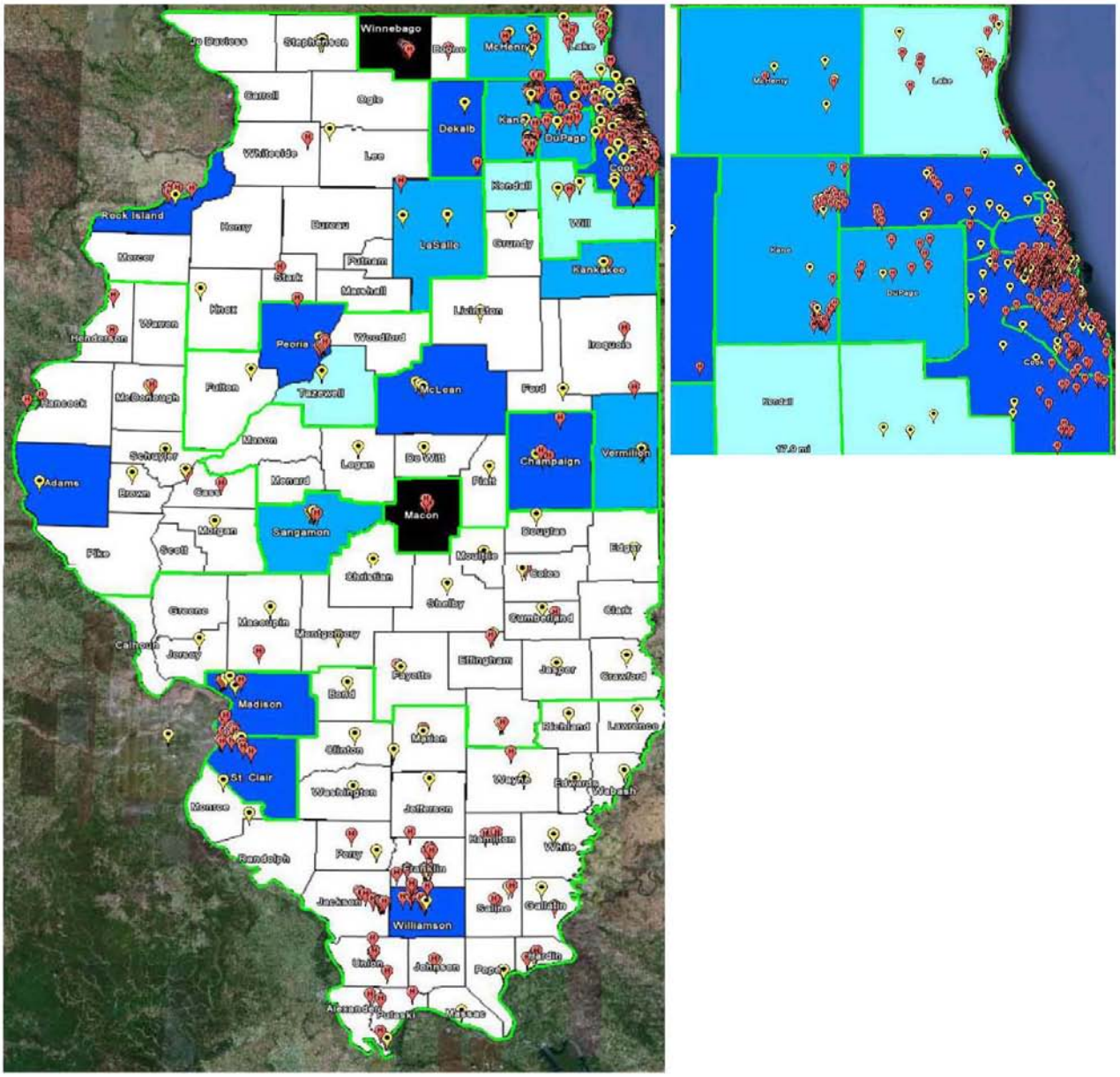
coverage options	Management; Individual Counseling							
Counseling Youth in Transition	Community Support; Targeted Case Management; Individual Counseling	✓	✓	✓	✓	✓	✓	✓
Job skills training & education	Community Support; Supported Employment; Prevocational Services	✓	✓	✓	✓	✓	✓	✓
Job readiness training – resumes, interview skills	Community Support; Supported Employment; Prevocational Services	✓	✓	✓	✓	✓	✓	✓
Job development – job placement services	Supported Employment	✓		✓	✓	✓	✓	
Transitional employment	Community Support; ??						✓	
Onsite employment	Supported Employment							
Job retention services – job coaching	Community Support; Peer Supports; Supported Employment	✓		✓	✓	✓	✓	
Peer Mentoring/support	Peer Supports	✓		✓	✓	✓	✓	✓

HDA MEDICAID FISCAL AUTHORITIES FOR EMPLOYMENT FUNCTIONS/SERVICES

Employment Functions/Services	Possible Medicaid Service Category	Money Follows the Person – Admin	Money Follows the Person -- Demo	Cash & Counseling	Aging & Disability Resource Centers
Education & Outreach on Employment programs	Individual Counseling; Community Support			✓	
Information & Referral to ENs, VR other employment supports & resources	Community Support or Targeted Case Management	✓		✓	✓
Employment planning/Work Incentives Analysis	Targeted Case Management; Community Support; Individual Counseling	✓	✓	?	✓
Customized Benefits Planning & Counseling	Targeted Case Management; Community Support; Individual Counseling		✓	?	✓
On-going Benefits Management	Community Support or Independent Living Skills		✓	?	✓
Individual Employment Plan service/goal setting		✓	✓	?	?
Providing advisement on health insurance		✓	✓	✓	✓

coverage options			
Counseling Youth in Transition	✓		
Job skills training & education		✓	
Job readiness training – resumes, interview skills		✓	
Job development – job placement services		✓	
Onsite employment		✓	
Job retention services – job coaching		✓	
Peer Mentoring/support		✓	

Appendix 6: Map of Federally Qualified Health Centers, Look-alikes, Community Mental Health Centers, and Percent of Poverty for the State of Illinois



Key

Health Care Centers and Look-alikes

Community Mental Health Centers

Percent of People at or below 138 Percent of Poverty who are Uninsured by All Ages

20% to 29%

30% to 39%

40% to 49%

50% & Above

CSH, Leveraging Medicaid 2010

U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation (ASPE) Office of Disability, Aging, and Long-term Care Policy entitled "Medicaid and Permanent Supportive Housing for Chronically Homeless,"