



Health Reform Implementation: Priorities for Providers of Permanent Supportive Housing October 2010

Permanent Supportive Housing (PSH) requires not only consistent access to housing via rental assistance but also access to coordinated, comprehensive physical and behavioral health treatment services. Too often, a lack of sustainable service resources stalls or prevents PSH development.

The Patient Protection and Affordable Care Act or PPACA (P.L. 111-148), also known as the Health Reform legislation, contained several provisions that, if taken advantage of, could provide the sustained services funding needed to build PSH at a scale that will end homelessness among chronically ill and particularly vulnerable individuals and families. Below is a list of those provisions with a brief summary of how they can serve homeless populations.

Medicaid State Options

1. Revised Home and Community-Based Services State Plan Option (Sec. 2402)

This provision gives states the option to offer home and community-based services through a Medicaid state plan amendment, which requires fewer administrative investments, rather than through a HCBS waiver. It targets individuals with incomes up to 300% of the maximum SSI payment and who have a higher level of need. In addition, states can extend full Medicaid benefits to individuals who are not otherwise eligible to receive these home and community-based services.

Since the populations served in PSH are often those needing home and community-based services, the services states can choose to reimburse under HCBS are also those needed to make supportive housing successful. Case management, individual service plan creation, psychosocial assessment, counseling, medication monitoring, substance use treatment, transportation, and life skills education are examples of what can be funded through the HCBS state plan option.

States benefit by strengthening the partnership between Medicaid and permanent supportive housing. Supportive housing helps Medicaid serve a very vulnerable, hard-to-reach and expensive population. Permanent supportive housing has been shown to reduce costs, improve health outcomes and help Medicaid create (or facilitate the creation of) “health homes” for these clients.

2. Coordinated Care for People with Multiple Chronic Conditions (Sec. 2703)

PPACA creates a Medicaid state plan option to permit Medicaid enrollees with at least two chronic conditions (including a substance use disorder), one condition and risk of developing another, or at least one serious and persistent mental health condition to receive “health home” services. Health Home services include: primary care, comprehensive care management, care coordination and health promotion, patient and family support, transitional care as health status changes, referral to community support services and use of health information technology to link clients to services. This proposal provides states exercising the option a 90 percent federal contribution for the costs of these health home services for two years.

The typical permanent supportive housing resident has multiple chronic conditions, qualifying them for these types of services. PSH is successful because case managers coordinate care for clients who have multiple health conditions and/or who experience serious mental illness. Many PSH providers either bill Medicaid or partner with an organization that receives Medicaid reimbursement and sometimes these care coordination activities are not eligible for reimbursement. However, without these activities, the care coordination (and resulting cost savings) would not be realized. This provision will allow states and community partners to illustrate the benefits of funding care coordination and assist PSH providers in creating health homes for residents.

3. Demonstration to Improve Hospital Utilization and Discharge (Sec. 2704)

Up to eight states can participate in this demonstration program, which is intended to evaluate integrated care models that improve hospital utilization. The program is a five year (2012 – 2016) demonstration. States can decide which categories of beneficiaries, categories of diagnosis, or particular regions of the state to evaluate. States must ensure that robust discharge planning, particularly for those requiring post-acute care, is among the measured program elements.

PSH has been shown to reduce improper hospital and emergency room utilization. PSH residents in a Chicago random assignment study reduced their emergency room use by 46 percent and their hospital use by 42 percent. In addition, discharging patients without ensuring they have a place to go and a way to continue follow-up care is a growing problem. This demonstration program will allow hospitals to receive Medicaid funding targeted to improve hospital utilization and improve discharge practices. Hospitals would find it to their benefit to partner with PSH providers to create a successful demonstration program.

Competitive Grants/Demonstration Projects

1. Community-based Collaborative Care Network and Health Teams Programs (Sec. 10333 and Sec. 3502)

These two competitive grant programs have been combined and could be funded in the FY 2011 budget that passes Congress this year. The Senate included \$40 million in their appropriations bill (the House has not made their appropriations bill public). Both of these programs will be operated by the Health Resources and Services Administration (HRSA).

The Community-based Collaborative Care Network is a Department of Health and Human Services (HHS) grant program to support consortiums of health care providers to coordinate and integrate health care services, manage chronic conditions, and reduce emergency department use for low-income uninsured and underserved populations. Eligible grantees include community health centers, hospitals, and local government.

The Health Teams program is also an HHS grant program created to help hospitals establish community-based, multi-disciplinary teams that provide primary care services to clients. The team must include behavioral health professionals and hospitals must agree to serve clients with chronic conditions. The purposes include reducing duplication of services, improving discharge planning, and improving health services for youth as they transition to adulthood.

Team-oriented approaches, such as Assertive Community Treatment, have successfully partnered with permanent supportive housing providers to deliver the comprehensive services residents need. Without

housing, these teams find it difficult to improve the health of their clients. Funding to improve health system coordination and the creation of health teams gives PSH providers an opportunity to partner with grantees.

2. Increased funding for Community Health Centers (Sec. 5601)

Under PPACA, the authorized funding level for Community Health Centers will incrementally be raised, resulting in an \$11 billion increase from 2011 through 2016. Health Care for the Homeless Clinics receive 8.7 percent of the community health center allocation. If appropriated by Congress, HRSA will devise a plan for distributing these funds which could include targeting very vulnerable, chronically ill populations.

3. Co-locating Primary Health and Behavioral Health (Sec. 5604)

The Substance Abuse and Mental Health Services Administrator can create a demonstration project for the provision of coordinated and integrated services to special populations through the co-location of primary and specialty care services in community-based, behavioral health settings. PPACA authorized \$50 million to administer this program from 2011-2014.

Coordinating primary and behavioral health services is necessary to create a health home for clients. This program will help behavioral health clinics deliver primary and specialty care services, potentially improving the quality of providers locally and increasing the number of potential partners for permanent supportive housing programs.

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