TEXAS | 2014

crosswalk

IMPROVING MEDICAID FINANCING
of Supportive Housing Services

CSH
The Source for Housing Solutions

This paper, with support from the Hogg Foundation for Mental Health and Enterprise Community Partners, details opportunities to improve Medicaid reimbursement for services in supportive housing. This investment would not only address the needs of vulnerable people, especially those experiencing chronic homelessness, but **also reduce health system costs by directing people away from expensive emergency room, mental health crisis interventions, and inpatient care**. We explore how Medicaid reimbursement is currently being used in Texas for supportive housing and identify opportunities to strengthen this connection. CSH contracted with Health and Disabilities Advocates to assist with conducting a Medicaid 'crosswalk' analysis which involved interviewing local supportive housing providers on their utilization of Medicaid billing and identifying opportunities for improvement.

This crosswalk process identified the services typically delivered in supportive housing and compared them to the benefits that are reimbursable through Texas' Medicaid program. We then asked supportive housing providers for feedback regarding their use of Medicaid reimbursement to pay for services, the constraints to doing so, and how services are financed when Medicaid reimbursement is not an option.

In addition to identifying these gaps in supportive housing services financing, we provide recommendations for connecting housing to the larger health system changes already in progress and for making policy changes to Medicaid. Together, these strategies will increase health and housing system partnerships, allowing Texas to achieve the cost savings seen in other states when supportive housing is integrated as part of Medicaid improvement strategies.

Supportive Housing

Supportive Housing is a proven solution for getting and keeping people with low- incomes, disabilities and housing instability (especially those who are homeless), into secure housing with appropriate support services. Multiple research studies have shown that permanent supportive housing is successful at improving mental health and substance abuse outcomes, improving overall health, and reducing re-entry into homelessness. Supportive housing not only improves health and functionality but contains costs to other public systems, including Medicaid (additional information provided below).

Supportive housing allows people who face the most complex challenges to live with stability, autonomy and dignity by combining affordable housing with wrap-around supportive services, such as case management, independent living skills, employment services and peer supports. Supportive housing requires capital, operating and service funding. The service funding is often the most difficult to obtain, as HUD, which provides most of the capital and operating funding for bricks and mortar and rent subsidies, only funds a small portion of the services, and is increasingly looking to other local, state, and federal sources to cover the service expense. Without high quality, voluntary services, most supportive housing residents have difficulty staying successfully housed, independently in the community.

HOUSING DESIGN

Supportive housing opportunities can be created in a variety of ways to meet the needs and preferences of tenants as well as the community. Broadly speaking, there are three primary approaches to creating the housing, each of them with their own benefits and challenges. Communities should determine the appropriate balance of these three housing models and ensure there are options that meet varying needs and promote tenant choice. The three strategies include:

- **Scattered site housing** in which apartments are identified and secured in buildings across a neighborhood or community. Landlords of these buildings lease units directly to tenants and/or master lease units to a supportive housing provider, who then sublets to supportive housing tenants.
- **Mixed tenancy housing** where supportive housing is interspersed – or a limited number of units are set-aside - within broader affordable housing and/or mixed use and mixed income housing.
- **Single site housing**, in which a majority of tenants – and in some projects all tenants- are people with histories of homelessness, disability (although not necessarily the same one) and/or chronic behavioral health conditions. Housing is located in the community and in proximity and with access to community services and activities.

SERVICE DELIVERY DESIGN

Case management is the most common service delivered in supportive housing. Case management is typically intensive, but the intensity varies over time – the key is that the service is tailored to the particular needs of each tenant. An array of services can be available 24/7 and are delivered by a variety of professionals, including social workers, certified alcohol and drug addiction counselors, psychiatrists, psychologists, peer counselors, nurses and doctors, and job training specialists. The services delivered to supportive housing tenants include linkage and referral to medical and behavioral health providers, transportation to medical appointments, medication adherence, health education, nutritional counseling, care coordination, medication management, alcohol and substance abuse services, nutrition counseling, transportation, money management, employment, mental health treatment, housekeeping, and others. Some of the services are provided to tenants on-site; other services are provided off-site through formal and informal linkages with providers. These supportive services assist tenants to access resources (employment training, health care, mental health counseling, medication management, etc.) that help them remain stably housed. And the reverse is also true, housing provides the platform for the tenant to access services, adhere to physician advice, properly store medications, and receive in home supports.

Case management and the support services residents are connected to are often not comprehensively covered under Medicaid. Therefore, agencies typically fund services through an array of sources. This includes federal grants; state, local and county funding; fundraising and volunteers. These sources often come with complex rules, narrow service delivery requirements and frequent renewal applications.

Supportive Housing Need and Effectiveness in Texas

In Texas, on any given night there are at least 34,500 people experiencing homelessness, including 7,700 chronically homeless people and 4,800 veterans. According to the Department of Housing and Urban Development (HUD) there were 9,055 units of supportive housing in Texas in 2012. Based on these numbers, which are quite likely undercounts of the populations, we need to at least double the amount of supportive housing in Texas, adding at least another 10,000 units. This does not include addressing the housing needs of other populations such as people residing in mental health institutions, nursing homes, ex-offenders, and others who would be better served in the community but will need supportive housing to do so successfully[1].

[1] Supportive Housing can also be used to adhere to Olmstead decision mandates - Department of Justice Guidance

Despite the shortage of units, Texas has already found some success using supportive housing. The Metro Dallas Homeless Alliance, for example, has focused on moving individuals who are chronically homeless into transitional and supportive housing, resulting in a 66% decrease in the number of chronically homeless individuals since 2004. In addition to reducing homelessness and meeting other housing needs, supportive housing saves money.

Supportive Housing Saves Public Dollars[2]

Based on a review of the research, there is much evidence that providing affordable housing with supportive services for populations with complex challenges can save states money and result in better health outcomes. In Chicago, the Housing for Health Partnership studied homeless individuals with inpatient hospitalization for chronic medical conditions. They found that supportive housing saved Medicaid over $22,000 per person, per year. (Sadowski et. al., 2009). In Massachusetts, a Housing First pilot for chronically homeless individuals demonstrated a savings of almost $9,000 per person in Medicaid costs one year post housing.[2] Finally, Maine performed a Medicaid cost analysis in rural areas that found almost a 46% reduction in health care costs for those in supportive housing.[3] These savings are also being studied in Texas.

In Fort Worth, Directions Home is a 10-year plan to make homelessness rare, short-term and nonrecurring in greater Fort Worth by 2018. It aligns the efforts of public, private and social service agencies in the community. Directions Home emphasizes an approach known as Housing First, which places homeless individuals in supportive housing with case management services, rather than sheltering them in temporary or transitional facilities. To date, more than 1,200 Fort Worth residents have found “the shortest way home” as a result.

A recent independent evaluation of Directions Home monitored the results for sixty-six formerly homeless adults who received permanent housing for six months. The participants reduced their number of visits to psychiatric emergency rooms (ER) by 50 percent, medical ER by 55 percent, and urgent care by 64 percent. This produced net expenditure diversion of $274,179 over six months.[4] The evaluators noted that evidence shows it takes at least 6 months to begin to see cost savings in supportive housing because it takes that long for residents to stabilize. They expect that these cost savings would accrue even more rapidly in subsequent months.

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[2] Massachusetts Housing and Shelter Alliance, 2011

[3] The Effectiveness of Permanent Supportive Housing in Maine, Mondello, McLaughlin, Bradley, (2009).

[4] James Petrovich and Emily Spence-Almaguer, "Evaluation of Directions Home Supportive Housing and the Use of Critical Service Systems: Preliminary Results," (UTA School of Social Work Community Services Center, August 2010)

Medicaid Financing Supportive Housing Services

As stated above, services funding is often the hardest piece of the supportive housing puzzle to put together. As states and communities prioritize supportive housing as essential to reducing health care spending and improving care for vulnerable populations, Medicaid is being identified as a way to provide stable services financing. Medicaid often does not reimburse for all of the services needed by supportive housing residents but maximizing Medicaid investment can allow for the re-allocation of non-Medicaid resources and increase the number of people served. This section explains Medicaid nationally, Medicaid in Texas and new opportunities for Medicaid coverage presented through Texas' 1115 waiver.

MEDICAID BASICS

Medicaid is a federal-state financial partnership that provides acute and long term care services as well as other services to eligible populations. Under federal law, states must cover certain populations ("mandatory groups[5]") and certain services ("mandatory services[6]"). States have the option to expand coverage to other delineated groups ("optional groups") and provide other delineated services ("optional services"). In addition to these listed mandatory and optional groups and services, states may request "waivers" to cover additional groups and services and to use Medicaid federal dollars in ways which would not normally be permitted under federal law. So, for Medicaid to benefit residents in supportive housing, it is important to analyze individual eligibility for Medicaid, the benefits included with eligibility, and which providers are able to bill Medicaid.

TEXAS MEDICAID ELIGIBILITY

Through the state Medicaid plan, Texas provides medical insurance to the federally mandatory groups described in Table 1 below. Currently, low-income adults who are not custodial parents of minor children or who are not disabled according to the Social Security definition of disability are not eligible for Texas' Medicaid program.

[5] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Eligibility/Eligibility.html
[6] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Medicaid-Benefits.html

TABLE 1: **TEXAS MEDICAID CATEGORIES OF ELIGIBILITY**

Families and Children *Non-TANF, Non-Disability Related*	Eligible Families and Children *Under TANF Limit*	Aged, Medicare and Disability Related	Buy In Programs
Pregnant Women and Newborns	TANF Adult	SSI (Disability Related) Adult	Medicaid Buy In for Children
Child 1-5	TANF Children (0-19)	SSI (Disability Related) Child Under 21	Medicaid Buy In for Workers with Disabilities
Child 6-18	—	Aged and Medicare Related	
Medically Needy	—	Disabled Individuals in Need of Long Term Care Services and Supports	
Foster Children			

Key
Orange = STAR managed care program
Black = STAR PLUS managed care program

TEXAS MEDICAID MANAGED CARE ARRANGEMENT

Medicaid managed care offers the opportunity to control state costs, produce efficiencies, give access to more individuals and provide more comprehensive care. Almost all areas of Texas now operate Medicaid in managed care systems called either STAR or STAR+PLUS. The system the person enrolls in depends upon their Medicaid eligibility category and the services the person requires (*Table 1 illustrates the difference*). Only children receiving SSI from birth – age 20 are not required to enroll in a managed care plan.

TEXAS MEDICAID MANAGED CARE AND SUPPORTIVE HOUSING SERVICES

Home and Community-Based Services

Home and community-based services (HCBS) help persons with disabilities, and some older persons, get the help they need to stay in their own homes and communities. Home and community- based services programs provide alternatives to nursing homes or other institutional settings that are both more costly and place more restrictions on the people who live there. The programs and services are available only to people in Texas who already have Medicaid or can qualify for Medicaid through the home and community-based services program.

STAR+PLUS, where it is operational, covers people who are disabled or that qualify for home and community based services through Texas' federally approved waiver program. The waiver is aimed at persons with intellectual and developmental disabilities, and for clients with chronic and complex primary care conditions who need long term services and supports, such as attendant care and adult day health care. To be eligible for the waiver services, the member must meet income and resource requirements for Medicaid nursing facility care and receive a determination that they meet the medical necessity/level of care for a nursing facility. While STAR+PLUS could cover people with disabilities who are homeless, the HCBS waiver services are not widely used for homeless populations because they cannot meet the HCBS criteria for the nursing facility level of care.

Behavioral Health Services: Statewide (excludes Dallas)

Historically, Medicaid-funded behavioral health services have been largely provided within the STAR managed care program and administered by the Local Mental Health Authorities (LMHAs)[7]. If a person is diagnosed with Major Depression, Schizophrenia, Bi-Polar Disorder or another designated illness defined in regulation, they will qualify for the state program and treatment (including case management and rehabilitation services) administered through the LMHA. The LMHA can also serve non-Medicaid eligible individuals ***but the capacity to do so is substantially limited by the available general revenue funding.*** Treatment is delivered through provider contracts with the STAR program lead entity or fee-for-service outside of the managed care arrangement. In addition, Texas provides substance abuse benefits for adults in Medicaid. The benefit offers outpatient services such as clinical assessment counseling and ambulatory detoxification as well as residential detoxification and substance abuse treatment. The substance use benefits are only available to persons eligible for Medicaid.

[7] The local mental health authority (LMHA) is an entity within a specified region responsible for planning, policy development, coordination, and resource development and allocation and for supervising and ensuring the provision of mental health care services to persons with mental illness in one or more local service areas.

Behavioral Health Services: Dallas

The exception to the STAR and STAR+PLUS program is the Dallas area (7 counties—including Dallas, Collin, Ellis, Hunt, Kaufman, Navarro and Rockwall) where behavioral health services including mental health, substance abuse, and case management are carved out of the STAR program and delivered through the NorthSTAR system. NorthSTAR is managed care and the MCO responsible for providing services is ValueOptions. The NorthSTAR program provides an integrated system of care with mental health care and chemical dependency services. The NorthSTAR program blends funding from state Medicaid, substance abuse treatment, and mental health authorities in order to provide a wide array of services beyond those eligible for Medicaid reimbursement. These additional services are paid for through savings derived from better management of services by the managed care program. Under this model, access to behavioral health services were expanded (non-Medicaid recipients can also be served under the program) *but* reductions to the capitated rate ValueOptions receives from the Texas Department of State Health Services to operate the program results in reductions in the case rate distributed to providers for each individual they serve. Currently, the case rate is $150 per person, per month which is not enough to cover services needed by those with complex health and social support needs. In comparison, Massachusetts Behavioral Health Partnership (MBHP) (a ValueOptions company) pays Massachusetts providers approximately $510 per person, per month if the person is chronically homeless with complex health needs. This is made possible through MBHP's contract with the state of Massachusetts and an higher capitated rate. *See Appendix 2 for more details.*

Medicaid 'Crosswalk' Analysis: Current Program And System Gaps

CSH and Health & Disability Advocates designed a survey for supportive housing providers to assess readiness for Medicaid financing. [8]The survey was designed to gather information on funding, billing practices, service delivery, professional licensure, tenant demographics, linkage, contracting and identified barriers. The purpose of gathering this information is to assess the current Medicaid financing in supportive housing in Texas and identify readiness to expand Medicaid financing for supportive services. In addition, select providers in Austin, Houston and Dallas were interviewed to gain a deeper understanding of their service delivery and financing model.

[8] The complete CSH/HDA survey tool is included in Appendix One.

These findings, based on information gathered from providers, key stakeholders, community organizations and state agency staff through our interview process, indicate that most supportive housing tenants do not currently have Medicaid; most supportive housing providers do not receive any Medicaid reimbursement; and almost all supportive housing providers provide case management and other services that help their tenants access and coordinate medical and behavioral healthcare services. In addition, the services that are Medicaid billable relate to behavioral health service packages through local STAR+PLUS or NorthSTAR programs. Therefore, there is variability in the services that can be billed depending upon geographic location.

PROVIDER ISSUES

Through our survey and interviews we engaged both providers who do and do not utilize Medicaid reimbursement. We found that the services these providers deliver are relatively the same. These services can be grouped in the following general categories: tenancy supports, outreach/in-reach services, transition services, case management, transportation, independent living skills, job training, domestic violence intervention, behavioral health, social recovery, benefits assistance, and routine medical services. Interviewed agencies also used similar staff professionals to deliver these services.

In Houston, a provider of supportive housing who does not bill Medicaid has to cobble together many local, state and federal funding sources, both public and private, to pay for the supportive services. For example, to pay for tenancy supports, a particular provider uses the federal Emergency Services Grant, Community Development Block Grant (CDBG) (through the City), HUD and Substance Abuse and Mental Health Services grants (SAMHSA). For outreach services, the provider utilizes CDBG, SAMSHA and HUD. United Way pays for transition services, and case management services are financed by HUD, SAMHSA and private sources. For employment services, there are some Department of Labor funds and some HUD supportive services. For clients with HIV/AIDS, there are some HOPWA funds. The administrative burden of managing all of these funding sources is high and gap funding is still required to provide comprehensive services.

Beyond being able to bill, providers must receive an appropriate reimbursement rate. In Dallas, ValueOptions, which administers the NorthStar program, can contract with a variety of entities to provide behavioral health services. Under NorthStar, almost all services in supportive housing (except tenancy supports) can be delivered as a billable service. These services are paid for as a single case rate which is $150 per month, per client. Providers report that this rate is too low for patients with complex needs; therefore, while the services can be billed to Medicaid, other services financing is needed to provide comprehensive supports. Otherwise, providers are incentivized to serve a large number of lower need clients where the $150 case rate covers their service need.

A San Antonio LMHA provider is able to bill all the services listed in the crosswalk under either traditional fee-for-service Medicaid, Targeted Case Management or Medicaid Rehab Option. The traditional Medicaid pays for counseling, credentialed staff and physician and psychiatrist/psychologist services. ***Because the LMHA is able to bill under Medicaid for almost all of the supportive services, it streamlines the billing process, and it receives more funding than the non-LMHA providers can achieve with multiple funding sources.***

Other challenges supportive housing providers face include:

- LMHAs provide many psycho-social rehab services in their clinics and only by LMHA staff. Keeping services in-house can make it difficult to expand services to new patients and change service delivery models to incorporate best practices, such as in-home counseling and case management. In addition, supportive housing providers have had difficulty partnering with LMHAs to bring their expertise with a specific, high need population that is served in supportive housing.

- Limited Provider Capacity to Bill Medicaid. 85% of the respondents to the survey do not currently bill Medicaid. Since the ability to bill Medicaid has been expanded to new providers, these agencies need technical assistance and training and funding to build administrative billing capacity and accreditation necessary to bill Medicaid.

- Providers serving populations who require supportive housing but do not have a mental health need do not have a mechanism for billing Medicaid for services outside of mental health services. Texas has recently taken steps to integrate primary and behavioral health care. These continued efforts should include expanding providers who can deliver supportive housing supports for populations beyond mental health.

ELIGIBILITY AND ENROLLMENT ISSUES

As described above, adult eligibility for Texas Medicaid is narrow. Single adults must have a physical or mental health disability that makes them eligible for SSI/SSDI or be low-income and require long-term support services. Our survey found that 44% of tenants are uninsured. Most likely many are not eligible for Medicaid, but this number also includes tenants who might be eligible for Medicaid *but not enrolled* at the time of entering housing. Limited Medicaid eligibility can hamper Texas' efforts to control costs for high need, frequent users of the health system. Without insurance, taxpayers and providers pay indirectly for the high service utilization and targeted efforts to contain costs are difficult to implement. These populations need managed care the most and are left to cycle in and out of care uncontrollably.

For example, in Dallas, those tenants who are not Medicaid eligible still receive services through the NorthStar system's indigent care category. While the service need for these residents is likely the same, the case rate used to pay for their services ($100) is lower than the case rate ($150) for the Medicaid eligible population. This is an additional disincentive for providers to engage this population.

Other eligibility and enrollment challenges include:

- Serving those who exit the criminal justice system is a challenge since Texas terminates Medicaid eligibility for those entering the correctional system who are already on Medicaid. When an individual is released from a correctional institution without Medicaid it takes many months to reapply and get a decision. This delay in receiving crucial health care (especially mental health care) can be a major cause of recidivism.

- Assisting individuals to enroll in SSI/SSDI is not a directly reimbursable service under Medicaid. Some agencies are able to bill for this service under Medicaid administrative claiming, but those providers who are not billing Medicaid do not have access to this funding.

SERVICE PACKAGE/MEDICAID BENEFIT ISSUES

As mentioned above, we surveyed providers' ability to deliver and receive Medicaid reimbursement for the comprehensive array of supportive housing services. The major service categories were: tenancy supports, outreach/in-reach services, transition services, case management, transportation, independent living skills, job training, domestic violence intervention, behavioral health, social recovery, benefits assistance, and routine medical services.

While service delivery models and financing differed for each agency interviewed, none of the providers who bill Medicaid were able to use Medicaid for tenancy support services. The LMHA could bill under the Medicaid Rehab Option to help an individual develop the skills to obtain and maintain housing. But the billing guidelines for MRO and TCM specifically prohibit billing for a case manager's time to help an individual find housing. Tenancy support services are things such as housing location assistance, landlord advocacy, eviction prevention, and navigating the housing application process. These supports are essential to supportive housing and could be reimbursed by Medicaid (see below for recommendations). Other service decisions varied by providers, the partners they engaged and the organization's mission. While how the service is delivered and if Medicaid reimbursed it differed, Medicaid and non-Medicaid eligible supportive housing residents need all these services. As the state explores new Medicaid policies to reduce costs for the high need, high cost population, providing a comprehensive set of services with an appropriate case rate will ensure success.

Providers also report that the package of services under the Texas Resilience and Recovery program have stringent utilization management guidelines and eligibility requirements that limit any flexibility or expansion to individuals who do not have specific diagnoses of schizophrenia, bi-polar disorder or major depressive disorder.

Texas Opportunities to Link Supportive Housing and Medicaid

CURRENT 1115 WAIVER ACTIVITIES

In 2011, Texas was granted federal approval for the largest Medicaid 1115 waiver in federal history, intended to expand managed care and change the state system for funding uncompensated care. This five-year waiver allows the State to conduct a phased in transition of Medicaid beneficiaries from fee-for-service to a managed care delivery system based on geographic service areas. It also provided approximately $62 billion in funding to help health systems improve and expand care to both Medicaid recipients and indigent patients. The Regional Health Partnerships (RHPs) are the anchor agencies for planning and distribution of this Delivery System Reform Incentive Payment, or 'DSRIP', funding under the 1115 Waiver. The waiver allows the RHPs to provide services of their choosing to currently uninsured and ineligible individuals, *such as those who are chronically homeless and who do not qualify for the Medicaid program*. It also allows the RHPs to deliver services in a comprehensive and integrated fashion, and provide access to more providers, like supportive housing providers, to bill for services. Each of 20 RHPs has proposed a plan for the administration and use of the funds in their catchment area. The plans have been sent to CMS for approval. A copy of each plan can be reviewed at http://www.hhsc.state.tx.us/1115-RHP-Plans.shtml.

With the options offered under existing Medicaid financing, the nation's traditional homeless housing and service providers have avenues for **brokering supportive services**. Initial funding proposals from the RHPs include many projects providing behavioral health and supportive services because untreated mental health and substance abuse disorders are associated with increased preventable hospital admissions and specialty care expenditures. Therefore, this presents an opportunity for supportive housing providers in particular to partner with the hospitals or healthcare providers in the RHP to provide supportive services that will keep residents out of expensive emergency rooms, avoid hospitalizations, and otherwise more effectively and inexpensively manage health conditions. For example, **proposed projects in Harris County, Dallas County, and Travis County will provide supportive housing tenants with patient navigation and chronic illness support**, through collaborations that include some combination of federally-qualified health centers, LMHAs, community service providers, and local hospitals.

UTILIZE STATE 811 PROGRAM

In 2012, the HUD 811 program was revamped to provide states with project-based rental assistance funding to create integrated permanent supportive housing units for people with disabilities. The Texas Department of Housing and Community Affairs, partnering with four health and human service agencies led by the Department of Aging and Disability Services (DADS) received an allocation of approximately 385 vouchers under the Section 811 Project Rental Assistance Demonstration Program. This demonstration will target institutionalized people with disabilities, youth with disabilities aging out of the foster care system, and persons living with serious mental illness. As a condition of receiving the vouchers, the State had to demonstrate that it will make appropriate services available to the tenants of the units. The 811 demonstration program represents an opportunity to establish the scope and cost of housing stabilization services needed outside of statutory or waiver-based Medicaid services.

ADDITIONAL OPTIONS TO IMPROVE MEDICAID SERVICES REIMBURSEMENT

The 'crosswalk' analysis explained above highlights areas of improvement needed to maximize Medicaid reimbursement and increase the availability of supportive housing services. As we have stated, supportive housing is essential to control costs for the most vulnerable, frequent users of health care services. The following recommendations offer ideas for how Texas policymakers could improve the existing Medicaid program and more efficiently use limited taxpayer resources.

Incentivize Managed Care Entities to Coordinate with Supportive Housing Providers

Managed Care Organizations should expand to cover the services provided in supportive housing and coordinate with supportive housing as a tool to improve health outcomes and reduce emergency room and hospital admissions, as well as eventual nursing home admissions. The State could include or encourage the use of supportive housing in managed care contracts through bonus and incentive payments for stabilizing high-cost members who are homeless or precariously housed. Other states have used shared savings models to incentivize managed care companies to avoid in-patient care or to rebalance long-term care.

Expand Outreach and Medicaid Enrollment for Supportive Housing Tenants

Less than 50% of the clients in supportive housing and/or receiving homeless services are currently enrolled in Medicaid, largely because of the historic ineligibility of the childless adult population and barriers to enrollment for those who may be eligible. Texas should encourage homeless services and housing providers to enroll people in the current Medicaid program, which can be facilitated by the SOAR (SSI/SSDI Access to Recovery) program. SOAR trained case managers can assist individuals with SSI/SSDI applications. Once an individual is eligible for SSI or SSDI benefits, he/she will automatically be enrolled in Medicaid. The receipt of SSI/SSDI benefits will help individuals access housing more readily, and the Medicaid eligibility will allow a service provider to potentially bill for Medicaid billable services.

Improve Medicaid and Supportive Housing for those with Mental Health Needs

Previously in Texas, only the Local Mental Health Authorities (LMHAs) were permitted to bill Medicaid under the Targeted Case Management and/or the Rehab Options. The services provided under both TCM and the Rehab option are services that may be paid for by Medicaid and are typically provided in supportive housing. The direction of the 83rd Legislature's Senate Bill 58 to fully integrate primary and behavioral health care under managed care Medicaid creates an opportunity to extend these services to a broader spectrum of members, delivered by a greater diversity of providers. As managed care is implemented, the State should track utilization of these strategies for high-cost Medicaid recipients, and take corrective action if utilization remains low.

1915 (i) State Plan Amendment

The 1915(i) state plan option allows states to cover traditional home and community based (HCBS) waiver services as well as an array of other services like supportive housing and supported employment under a Medicaid State Plan Amendment (SPA). In the current 1915(i) State Plan Amendment proposal, these services are only offered to individuals with developmental disabilities. Recently, Texas has proposed a 1915(i) State Plan Amendment that would cover a small population of individuals with forensic commitments to State Hospital (noted below). Expanding this even further to include individuals with mental illness would allow Texas to receive federal matching funds for services that have historically been funded with state and local funds.

Medicaid Health Home State Plan Amendment

Texas should apply for the Medicaid Health Home State Plan Amendment under the Affordable Care Act, which provides 90% federal Medicaid financing for coordinated care for patients with severe mental illness, substance abuse and/or chronic conditions for the first 2 years. Services can include services required by those living in supportive housing and make supportive housing an integral part of care coordination to improve health outcomes and reduce costs. The health home service delivery model would complement the goals of the Texas 1115 waiver and the Regional Health Partnerships (RHP). Health homes bring together groups of providers to share health information and comprehensively coordinate care and services for high need populations. Multiple health home networks could be created within each RHP to bring the regional coordination being implemented by the RHPs down to the local level. This would help the RHPs direct appropriate services and potentially reduce costs for high need, often high cost populations. The enhanced federal match rate could assist the state and RHPs establish the health homes which would help Texas achieve the 1115 waiver's goals.

Employ Current Available Strategies for Populations Coming Out of Correctional Facilities or Other Institutions

There are three of the aforementioned strategies that Texas can pursue to assist those coming out of correctional facilities or other institutions to assure they remain in the community. First, Texas is considering a 1915i State Plan Amendment to serve people being committed for Restoration of Competency offenses of homelessness like, people with more than four commitments, and people with 46b commitments. Second, providers could propose to serve a broader swath of the criminal justice population under the 1115 Health Care Transformation and Quality Improvement proposed project. Third, Texas could suspend rather than terminate Medicaid eligibility during incarceration, a process implemented in other states. This small step ensures that people who are eligible for Medicaid can receive coverage as soon as they are released rather than relying on them to re-apply for Medicaid and be found eligible through a complex system which at best creates a delay in coverage.

Opt for Medicaid Expansion

Texas should consider expanding Medicaid in 2014 to adults between ages of 19-64 with income under 138% of the Federal Poverty Level to provide increased federal financing for supportive services including behavioral and medical care in order to improve health and reduce costs. In the alternative, Texas should pursue a state specific solution approved by the federal government to maximize federal funding and provide insurance to the currently ineligible population. CMS recently gave Arkansas and Iowa state specific solutions to expand Medicaid insurance to a low income population.

Moving Forward

Supportive housing is a key element as federal, state and local health policy makers work to control costs and improve care for the most vulnerable. Now is the time to take advantage of mainstream health system and Medicaid changes in order to increase the number of available housing units. Many Texas supportive housing providers are well-positioned to deliver services and housing to the most expensive health system users but need changes in Medicaid managed care to move forward. There are several options for how to improve Medicaid policy which would also increase the federal support to address Texas' health system inefficiencies. Allowing Medicaid reimbursement and service delivery to better align with housing is a win-win for all parties by reducing cost, improving care, and improving access.

APPENDIX ONE: MEDICAID READINESS ASSESSMENT FOR PROVIDERS

CSH and Health & Disability Advocates designed a survey for supportive housing providers to assess readiness for Medicaid financing. The survey was designed to gather information on funding, billing practices, service delivery, professional licensure, tenant demographics, linkage, contracting and identified barriers. The purpose of gathering this information is to assess the current Medicaid financing in supportive housing in Texas and identify readiness to expand Medicaid financing for supportive services.

In order to ensure that the survey was accurately designed to elicit the desired information, CSH and HDA developed a leadership committee to provide background information on Medicaid financing and supportive housing, review key reports and past findings on supportive housing in Texas, and review proposed survey questions. We then tested the draft survey with key providers and revised the questions accordingly prior to dissemination. We further reviewed the responses to the survey and followed up with providers to clarify or elaborate on responses. Finally, we supplemented and verified our survey findings with extensive information and feedback gathered at the two day CSH Statewide Supportive Housing conference in September 2012.

Survey Results

There were nineteen unduplicated responders to the survey; 16 responders are supportive housing organizations or organizations that provide housing and/or other supportive services; 1 responder is an LMHA. The remaining responses came from a school district, an education services center and an advocacy collaborative.

Demographics and Access to Healthcare for Service Population

- Of the clients that are receiving services from the survey responders:
- 80% of tenants are adults ages 19-64, 17% are under age 19, and only 3% are over age 65.
- 36% of tenants have Medicaid and 44% are uninsured.
- 29% of tenants have SSI or SSDI.
- 27% of tenants have a forensic record.

Service Delivery and Reimbursement

- 85% of responders do not bill Medicaid.
- The most commonly provided services are case management, support services, service coordination, and crisis assessment and intervention.
- Approximately 75% of responders employ or contract with case managers and 80% employ or contract with social workers (including MSW and LCSW).
- Approximately 50% of responders employ or contract with professionals who treat substance abuse, including substance abuse treatment specialists, certified chemical dependency specialists, and alcohol, substance abuse and drug counselors.
- Approximately 55% of responders employ or contract with qualified mental health professionals; 25% of responders employ or contract with peer or certified peer specialists.
- Approximately 45% of responders employ or contract with employment specialists.
- Almost half of responders contract with other medical providers, such as doctors, psychologists and psychiatrists.

Reimbursement

85% of responders reported that they did **not** receive any Medicaid reimbursement either directly, through managed care, or through an LMHA representing an opportunity to maximize Medicaid financing for supportive services.

Key Findings

Linkage, contracting, and co-location are important tools to increasing service coordination, improving care coordination, expanding access to services, and maximizing Medicaid financing.

- Generally only the LMHAs are able to bill Medicaid for case management, psycho-social rehab, and other mental health and substance abuse treatment services.
- LMHAs do not contract regularly with supportive housing providers to allow Medicaid billing and expanded non-LMHA provided services.
- 24% of responders reported delivering care coordination services which may represent an opportunity to expand competencies in this area to improve health outcomes and maximize Medicaid financing.
- Approximately 50% of responders contract with other medical providers, such as doctors, psychologist and psychiatrists, that may expand opportunities for care coordination and impact on health outcomes.
- Over 50% of the responders reported some type of coordination with a mental health agency, LMHA, public health provider, hospital, FQHC and/or a Behavioral Health Provider. Since 24% delivered care coordination services, it may represent an opportunity to expand competencies in this area to improve health outcomes and maximize Medicaid financing.

These findings, based on information gathered from providers, key stakeholders, community organizations and state agency staff through our interview process, indicate that most supportive housing tenants do not currently have Medicaid; most supportive housing providers do not receive any Medicaid reimbursement; and almost all supportive housing providers provide case management and other services that help their tenants access and coordinate medical and behavioral healthcare services. In addition, some supportive housing providers are using strategies to maximize Medicaid financing through co-location with medical providers and other creative strategies; however, there are many missed opportunities for other supportive housing providers to enroll more of their tenants in Medicaid and receive Medicaid reimbursement for providing supportive services and care coordination.

APPENDIX TWO: BEST PRACTICES FROM OTHER STATES

Before the Affordable Care Act was passed, the most common avenues for funding supportive housing services with Medicaid funds included the Medicaid Rehab Option, Targeted Case Management State Plan Amendments, and Home and Community-Based Services (HCBS) Waivers. The following are some state examples of best practices using Medicaid to finance supportive services in supportive housing settings.

MEDICAID DEMONSTRATIONS AND WAIVERS

Illinois

Illinois sought and received federal approval to provide Medicaid coverage to low-income adults without minor children living in Cook County through an 1115 Waiver. This population transitioned to Medicaid coverage under the ACA in 2014 when the state opted to create the new Adult Medicaid eligibility category. Normally, a state could do this "early expansion" of Medicaid without seeking a Waiver. However, in this case, Illinois needed to establish this through the Medicaid waiver authority because the Cook County waiver only covers persons in one county of the state as opposed to statewide coverage. The State of Illinois and Cook County Health & Hospitals System (CCHHS) operate this new program, called CountyCare. CountyCare will provide coverage for up to 114,000 currently uninsured patients, as CCHHS transforms into a patient-centered continuum of care. This transformation is changing the way that patients enter CCHHS, as they will be assigned intelligently (based on risk, complexity and need) to patient-centered medical homes instead of relying on the emergency department for basic services while waiting for new appointment availability.

CountyCare will change the way that care is delivered at the clinic site, as medical home teams built around primary care providers will coordinate all services needed by their own panel of patients, supported by care management and information technology. It is also changing the way that services are delivered within the broader system, as emergency, specialty outpatient, diagnostic and inpatient services are reconfigured to assure that the care of patients is coordinated by their medical home and that they are returned there. Because CCHHS does not currently have the capacity to provide all the specialty and inpatient services, CCHHS will work with other providers caring for similar populations and develop new partnerships to assure adequate primary care capacity and geographic accessibility.

This waiver will not only bring much-needed primary and specialty care to tenants of supportive housing, it will also reduce or eliminate some expenses that supportive housing providers that have been paying for, such as medications, for tenants who had no access to medical services.

Connecticut

Connecticut provides home-based care management and rehabilitative services connected to subsidized rental apartments for individuals with mental illness discharged or diverted from nursing homes. This program, known as the Working for Integration, Support and Empowerment (WISE) program, pairs services through one of the State's 1915c Home and Community Based Services (HCBS) waiver with State Rental Assistance Program vouchers to create a housing and services model that very closely resembles supportive housing. The WISE program uses 3 different benefit packages. The Community Support Program provides mental health and substance abuse rehabilitation services and supports using a team approach. The Recovery Assistant package consists of supportive assistance provided face-to-face that enables a participant to maintain a home/apartment, encourages the use of existing natural supports, and fosters involvement in social and community activities.[9] The Short-Term Crisis Stabilization service package consists of face-to-face mental health and substance abuse services. All of these services are paid through Medicaid.

ACCOUNTABLE CARE ORGANIZATIONS

An Accountable Care Organization is a type of payment and delivery reform model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients. A group of coordinated health care providers form an ACO, which then provides care to a group of patients. The ACO may use a range of payment models (capitation, fee-for-service where a Medicaid payment provider is reimbursed for each individual service provided usually in 15 minutes increments, etc.). The ACO is accountable to the patients and the third-party payer for the quality, appropriateness, and efficiency of the health care provided

[9] Understanding Supportive Housing Services and Potential Medicaid Reimbursement, Corporation for Supportive Housing.

ILLINOIS – ACCOUNTABLE CARE ORGANIZATION

In Chicago, Together4Health, a partnership led by Heartland Health Outreach (HHO) has created an Accountable Care Organization model. HHO was selected by the Illinois Medicaid office to manage a coordinated care entity (CCE) that will coordinate care for people on Medicaid with chronic health conditions. The partnership encompasses primary care physicians, hospitals, dentists and behavioral health professionals. The goal of the coordinated care entity is to improve how participants experience health care, improve the health of the participants, and reduce the per capita costs of care for the participants. In addition to health care entities, Together4Health also includes supportive housing providers. Supportive housing providers will collaborate with the health care providers and potentially share in the care coordination fees. The tenants of the supportive housing providers in the network will refer their tenants to Together4Health, who will serve as the primary care provider and care coordinator. The team of housing providers and health providers will work together to keep people housed and to ensure that their health care needs are met. The results should reflect decreased costs to the health care system, and potentially decreased costs of providing some supportive services through the housing partners.

HEALTH HOME MEDICAID STATE PLAN AMENDMENT

The current Health Home concept began as 'Medical Home' provider networks created in the 1960s to improve services and outcomes for children with special health care needs. Medical homes were largely primary/physical health care focused. Over time, the lessons learned from these medical homes have been applied to adults. The new ACA Health Home language shows recognition that behavioral health treatment and social issues must be addressed to deliver patient-centered services and achieve positive outcomes.
Health homes are designed to be person-centered systems of care that facilitate access to and coordination of the full array of primary and acute physical health services, behavioral health care, and long-term community-based services and supports. Health Homes can improve health care quality and clinical outcomes as well as the patient care experience, while also reducing per capita costs through more cost-effective care.

The State Option to Provide Health Homes for Enrollees with Chronic Conditions, section 2703 of the Affordable Care Act (ACA), provides enhanced federal funding for states that are planning to expand or implement a health home initiative that will serve individuals with chronic conditions – provided certain criteria are met. States electing this option will receive an enhanced Medicaid federal reimbursement for 8 fiscal quarters for health home services to chronically ill populations[10]. These services can be delivered by a designated provider, a team of health care professionals partnering with a designated provider or through a health team.

[10] To see approved Health Home State Plan Amendments - http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Approved-Health-Home-State-Plan-Amendments.html

NEW YORK – HEALTH HOMES

New York has an approved Health Home State Plan Amendment targeting people with mental health needs, those with chronic health conditions and those living with HIV/AIDS. These health home networks can be lead by a variety of providers (including: managed care plans, hospitals, behavioral health providers and community health clinics) and seeks provide care coordination and disease management to address the "whole person," including both mental illness and chronic medical conditions. These networks are creating multidisciplinary teams made up of medical, mental health, chemical dependency treatment providers, social workers, nurses and other care providers led by a dedicated care manager who will assure that enrollees receive needed medical, behavioral, and social services in accordance with a single plan of care. **Housing is among the required elements of the health home networks**. The standards were developed with input from a variety of stakeholders including hospitals, clinics, physicians, mental health experts, chemical dependency treatment experts **and housing providers**. Optional team members may include nutritionists/dieticians, pharmacists, outreach workers including peer specialists and other representatives as appropriate to meet the enrollee needs (**housing representatives,** entitlement, employment). All members of the team will be responsible for reporting back to the care manager on patient status, treatment options, actions taken and outcomes as a result of care management. Providers are paid a per member, per month rate based on geographic location and complexity of need. For example, health home networks in downstate NY (New York City) serving people with serious mental illness receive a $155 PMPM for people with low severity of illness, $217 for people with mid-severity of illness and $516 for people with high severity of illness. In order to receive payment for an individual, they must have received one unit of service per quarter.

MANAGED CARE MODELS

Managed Care models vary widely but generally consist of some form of capitated payment to manage the health care of a defined population of Medicaid recipients. Capitation rates are set based on actuarial and utilization data and require the Managed Care Organization (MCO) to provide all required Medicaid state plan services for a monthly per member rate. However, this model also allows MCOs to provide expanded services in a more flexible delivery system than the traditional fee for service model. For example, MCOs may not need waivers or the Health Home option to provide additional services for members who are incurring high costs.

Managed care contracts have a negotiated capitated rate. Within that rate, they have flexibility to provide services beyond their contract in order to meet their defined health outcomes. For instance, the focus on keeping individuals out of institutional care, including hospitals, could encourage managed care companies to pay for supportive housing for high-need individuals who would be able to maintain their health in housing better than in a homeless shelter. Supportive housing providers can contract with MCOs to provide non-traditional Medicaid services such as intensive case management to save money and improve health outcomes. For example, Deblyn Health Concepts (located in Houston, Austin, San Antonio) employs two social workers (MSWs) and a nurse who provide intensive case management for Medicaid recipients leaving the hospital after an acute inpatient stay and returning home. They started a pilot project that demonstrated significant cost savings and improved care enabling them to prove to managed care companies that their model of home care could save managed care capitated costs. They now contract with several managed care companies to provide case management in the home for transitional care and rehabilitation care.

MASSACHUSETTS – MANAGED CARE

The Massachusetts Behavioral Health Partnership (MBHP) developed a behavioral health managed care model that could support Members who were chronically homeless in a Housing First program. The program includes eight strategic partnerships between behavioral health providers in the MBHP network and non-network housing programs that have available housing vouchers from Federal or State funded housing grants that could be used for MBHP Members to create free-standing or congregate model Housing First units. Through their managed care contract and to meet the outcome measures, MBHP worked with the state to allow them to create a new benefit – the Community Support Program for those Experiencing Chronic Homelessness (CSPECH). MBHP's state contract included the Community Support Program (CSP) as a benefit for their members. MBHP used this as a foundation to create CSPECH and they have seen excellent results – reduced health care costs, improved health outcomes and housing stability.

To participate in CSPECH, applicants had to meet three important entry criteria: 1) they had to be covered under the MBHP insurance plan; 2) they had to meet the criteria of the Housing and Urban Development for chronic homelessness; and 3) CSPECH participants had to meet medical necessity criteria for CSP services. Additionally, participants must either be receiving intensive outreach prior to living in a Housing First model or must be currently living in a Housing First model. The CSPECH benefit is specifically designed to allow Medicaid to reimburse for the care coordination and case management which are not included in a basic Medicaid plan. The innovation MBHP brought to CSPECH was to pay for these services using a bundled rate payment structure. MBHP pays the service providers **$17 per day per person** to receive any mix of the services. Bundling the services into a single payment structure streamlines provider administration and reimbursement. The state included the Community Support Program (CSP) as part of an 1115 waiver.