



## **Proposed Language for Dear State Medicaid Director Letter As of August 30, 2011**

RE: Coverage and Services Opportunities  
for People Experiencing Homelessness

Dear State Medicaid Director:

The purpose of this letter is to inform States of the opportunities to leverage Medicaid coverage for people experiencing homelessness who need Medical Respite Care services and Permanent Supportive Housing in support of President Obama's plan to end homelessness: Opening Doors: Federal Strategic Plan to Prevent and End Homelessness. As part of a housing continuum, Medical Respite Care and Permanent Supportive Housing can work together to reduce health system costs and improve outcomes for people experiencing homelessness.

This guidance highlights current research illustrating the advantages of coupling housing and services for currently eligible populations experiencing homelessness, as a strategy to improve health outcomes while reducing Medicaid costs. Through the Medicaid program, there are various opportunities for States to reach these results, and this letter describes those options:

1. Section 1915 (c) Home and Community-Based Waivers
2. Section 1915 (i) State plan option
3. Health Homes for those with Chronic Health Conditions
4. Community First Choice
5. Optional Benefits and Services

Finally, this letter explains steps States can consider to determine which of these options would be the most beneficial.

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## Background

On any given night, around 110,000 people are chronically homeless – meaning they have been homeless for over 12 months, or repeatedly over the previous three years. **Many of the 110,000 live with multiple chronic health conditions.** Research has shown that 45% of homeless people report having a mental health issue in the last year and 57% report having a mental health problem in their lifetime. In addition, 62% reports battling to overcome a substance use addiction. It should be noted that these statistics rely on self reporting which means actual numbers are likely much higher. In addition, a recent Corporation for Supportive Housing (CSH) initiative in California and New York titled the Closer to Home Initiative found that 8 percent were living with HIV/AIDS, 16 percent had hypertension, 8 percent had heart disease and 14 percent were diabetic. And, it is important to remember that these conditions rarely occur alone; among the over 20,000 people surveyed through Community Solutions' 100,000 Homes Campaign, which seeks to identify the most medically vulnerable people living on the streets and help them back into housing with services and supports, 22% of respondents live with a chronic health condition, substance addiction, and mental health condition. These co-occurring conditions require coordinated, integrated physical and behavioral health care delivered by multi-disciplinary teams with an emphasis on individualized health navigation to assist individuals to participate in necessary care.

Those who are homeless and living with chronic health conditions are often either enrolled in Medicaid or eligible to do so. The 100,000 Homes Campaign has also found that 23 percent of those determined to be vulnerable were currently enrolled in Medicaid and 45 percent apparently had no insurance. Many of this later group would likely be eligible for Medicaid once they were able to apply for Supplemental Security Insurance (SSI) or Social Security Disability Income (SSDI). Starting in 2014, most will be eligible to enroll in essential health benefits, at a minimum.

People experiencing homelessness tend to lack a usual source of primary care and, as a result, delay seeking medical attention. They, therefore, rely on emergency rooms for their care, and their unmanaged illnesses often warrant inpatient care. Across the nation, frequent hospital users place significant burdens on already-overwhelmed hospital emergency departments, when, if conditions were addressed earlier, regular community care could have mitigated the problem. In each community participating in the 100,000 Homes Campaign, nearly 21% of individuals experiencing homelessness report frequent use of hospitals; among the subset who are most vulnerable, that proportion doubles to 45%. Therefore, states and localities have found that one way to reduce in appropriate utilization and as a result Medicaid expenditures is to stabilize this vulnerable population and provide a continuum of housing and services that includes Medical Respite Care and Permanent Supportive Housing.

Medical Respite Care is acute and post-acute medical care for homeless persons who are too ill or frail to recover from an illness or injury on the street, but who are not ill enough to be hospitalized. (Note these types of services are directed specifically at homeless persons and are

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different than the caregiver support known as “respite for caregivers.”) Medical Respite facilities are often operated by Health Care for the Homeless FQHC providers, and may be located in a variety of settings, to include freestanding facilities, nursing homes, homeless shelters, and transitional housing. Medical Respite Care enhances recovery and reduces risks of re-hospitalization. Medical respite can also be a safe, short-term housing solution prior to placement in appropriate permanent housing, with necessary supports.

Permanent Supportive Housing is a proven strategy for people whose health care needs are not urgent but who require treatment and support to manage chronic conditions, including mental illnesses and substance addiction. Supportive housing, coupling permanent housing with supportive services, has been shown to successfully stabilize people who were previously chronically homeless or are at risk of homelessness due to mental illness, substance use or physical health impairments. Increasingly, health organizations such as hospitals, community mental health clinics, substance use treatment providers, local public health agencies, Federally-Qualified Health Centers (including Health Care for the Homeless programs) provide services for Permanent Supportive Housing residents. These services include intensive care coordination, behavioral health treatment, primary care, transportation, and patient navigation services to help tenants make their appointments and follow their treatment plans. For chronically homeless individuals with complex post-acute care needs, Medical Respite Care prior to placement in Permanent Supportive Housing will often optimize recovery and minimize risk of relapse as an alternative to street life.

Evidence demonstrates that Medical Respite Care and Permanent Supportive Housing can reduce Medicaid costs for frequent utilizers of health services.

- While the average hospital stay for most patients is 4.6 days, those who are homeless average twice as many days.<sup>1, 2</sup> But Medical Respite Care programs have demonstrated reduced lengths of stay by enabling cost-effective discharge plans, and can reduce subsequent admissions by 50% within a 90-day period.<sup>3, 4</sup>
- A recent study in Seattle showed that placing people with chronic inebriation currently eligible for Medicaid into housing saved Medicaid 41 percent by reducing visits to emergency rooms and inpatient hospital stays.
- The Corporation for Supportive Housing’s Frequent Users of Health Systems Initiative found that participants had over \$58,000 on average in emergency room and hospital inpatient stays per person per year while they lived on the streets. Two years after placement in housing, residents incurred only \$19,000 in similar costs.
- A study in Chicago found that Permanent Supportive Housing saved almost \$25,000 per person per year in Medicaid costs, with an additional almost \$9,000 saved in nursing home expenditures.
- In Portland, Maine, a study found that Medicaid costs were reduced by almost \$6,000 per resident per year through supportive housing.

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- Direct Access to Housing in San Francisco evaluated one of their many housing programs and found that supportive housing reduced nursing home costs for their residents by \$24,000 per person, per year--a reduction of almost \$2 million per year.

The federal strategic plan, *Opening Doors*, identifies Medicaid as an essential funder of services in supportive housing. By partnering with programs supported by HRSA (e.g., health centers/ FQHCs) and SAMHSA (through services in supportive housing grants), Medicaid can help supportive housing tenants and medical respite care clients access health services and maintain housing. These partnerships help accomplish the objectives identified in the federal plan, in which President Obama provides a blueprint for how federal agencies can work together to end homelessness. Objective 7 of *Opening Doors* is to “Integrate primary and behavioral health care services with homeless assistance programs and housing to reduce people’s vulnerability to and the impacts of homelessness.” Please go to: [http://www.usich.gov/opening\\_doors/](http://www.usich.gov/opening_doors/) to see the full version of *Opening Doors*.

Opening Doors is the federal complement to the hundreds of 10-year plans to end homelessness developed by communities and statewide collaborative throughout the country.<sup>5</sup> With permanent housing solutions in place, respite care is a needed bridge to supportive housing, as well as a proven strategy to improve hospital discharge planning, reduce re-admission rates and promote post-acute health outcomes for vulnerable homeless people. Lead federal offices, including CMS, are finding willing partners in state and local safety net systems, which have developed integrated approaches to managing services for the most vulnerable and most expensive consumers.

#### Health Care Providers Involvement in Connecting Housing to Services

Community Health Centers, including Health Care for the Homeless grantees, have played an increasingly important role in serving homeless populations, providing services in both respite and supportive housing settings. In 2010, health centers saw nearly 20 million people, and just over one million were homeless (though this is likely a conservative estimate). These community providers are among those poised to be the health home and service venue for those living in Permanent Supportive Housing, helping reduce the frequency of ED visits and prevent illnesses and injuries from warranting hospitalization. Medicaid beneficiaries who have access to and use health centers have 19% fewer ED visits and 11% fewer ambulatory case sensitive hospital admissions.<sup>6</sup>

Behavioral health clinics are also appropriate service providers for residents of supportive housing. Often mental health and substance use agencies realize that their treatment services have better outcomes if stable housing is a factor in successful recovery. It is difficult to quit using drugs, reduce alcohol use, or take medication while living on the streets or in shelter. Some clinics actually operate housing programs while others partner with community-based housing providers - both models provide Medicaid reimbursable services.

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Finally, hospitals can be great resources to address the health needs of people experiencing homelessness. Hospital-based frequent use initiatives that offer care management to people with multiple needs can realize better results if they are connected to permanent housing providers in the community. Once housed, with continued care management, clients are more likely reduce hospital inpatient stays, to keep appointments, improve eating habits, can safely take and store medications, reduce emergency room use and seek care before conditions reach a crisis state. Thus, people will stay out of the hospital because their needs are met by less expensive community resources.

### Medicaid Mechanisms

Summaries of Medicaid service design and coverage opportunities that are available are outlined below.

#### **1. Home and Community Based Services (1915 c)**

Under section 1915(c) of the Act, States may design HCBS waiver programs. The section 1915(c) HCBS waiver program is the predominant Medicaid program for providing long-term services and supports in the community as an alternative to an institutional setting, such as a hospital or nursing home. The HCBS waiver authority can be target specific populations and provide services specific to those populations' needs. Services such as 24 hour emergency care, crisis management, independent living skills, extended personal care, respite care, transportation services and supported employment are common services to stabilize community living, and can be reimbursed by Medicaid under an HCBS waiver. These waiver services (along with State plan services such as those listed below under heading 5) can assist individuals to lead stable lives in the community by furnishing them critical supports in their living arrangement.

#### **2. Home and Community-Based Services State Plan Option (1915 i)**

*The Home and Community-Based Services State Plan (section 1915(i)), as we noted in our letter of August 6, 2010, allows States to cover “case management, homemaker/home health aide, personal care, adult day health, habilitation, and respite care for caregivers services. In addition the following services may be provided to persons with chronic mental illness: day treatment, other partial hospitalization services, psychosocial rehabilitation services, and clinical services.”* As a result of changes made through the Affordable Care Act, CMS can approve proposed plan amendments that will target these services to specified populations, such as people with severe mental illness. The need for “institutional level of care” is not required. The Section 1915(i) HCBS program also gives states the option to create a new Medicaid eligibility category (based on the criteria used to develop the State’s 1915(i) HCBS program) allowing access to HCBS to individuals who are not eligible for the Medicaid program. The Medicaid HCBS 1915(i) state plan amendment option can play a role in helping ensure funding stability for services in Permanent Supportive Housing and Medical Respite Care.

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### **3. Health Homes for Enrollees with Chronic Conditions**

As explained in our letter of November 16, 2010, the PPACA includes a new state plan option titled, the “Option to Provide Health Homes for Enrollees with Chronic Conditions.” This new Medicaid option was established as a means of reducing costs and improving health outcomes for people who have chronic diseases by better integrating and coordinating primary, acute, behavioral health and long-term care services. Supportive housing and medical respite care programs can be essential elements of health homes targeting chronically ill clients. Health Homes under this plan option must define populations based on clients’ diagnosed chronic conditions. However, given the crossover among those with multiple chronic conditions and homelessness, states can consider including supportive housing and medical respite as essential elements of health homes.

### **4. Community First Choice**

Section 2401 of the Affordable Care Act creates a new State Plan option to provide home and community-based attendant services and supports (Community First Choice Option) through section 1915(k) of the Social Security Act (the Act). This provision will be effective October 1, 2011. Community First Choice utilizes a person-centered plan, and allows for the provision of services to be self-directed under either an agency-provider model or a traditional self-directed model with a service budget. States can make available home and community-based attendant services and supports to assist in accomplishing activities of daily living, instrumental activities of daily living, and health-related tasks through hands-on assistance, supervision, or cueing. Community First Choice also allows for transition costs (such as security deposits for an apartment or utilities) and the purchase of bedding, basic kitchen supplies, and other necessities required for transition from an institution. In addition, Community First Choice allows for the provision of services that increase independence or substitute for human assistance to the extent that expenditures would have been made for the human assistance, such as non-medical transportation services. This option also allows for the purchase of back-up systems or mechanisms (such as the use of beepers or other electronic devices) to ensure continuity of services and supports. States that elect to provide the Community First Choice option will receive an increase of 6 percent in their Federal Medical Assistance Percentage (FMAP) for the provision of these services. For more information about Community First Choice, CMS has released a proposed rule. Please visit <http://www.gpo.gov/fdsys/pkg/FR-2011-02-25/pdf/2011-3946.pdf> for more information.

### **5. Optional Benefits and Services**

In addition to the waiver and state plan options discussed above, there are also individual optional benefits and services that Medicaid agencies can adopt that will support services in supportive housing.

The *Medicaid Rehabilitation Option* offers rehabilitative services that are defined in 42 CFR §440.130 as “any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum

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reduction of physical or mental disability and restoration of a recipient to his best possible functional level.” Assertive Community Treatment (ACT) teams are often funded through this option and are used to perform outreach and 24/7 support services to supportive housing residents or those receiving services within a Medical Respite Care program.

*Targeted Case Management* enables states to target case management services to specific individuals or to individuals who reside in specified areas. States such as Minnesota have included chronically homeless populations among those eligible for TCM benefits. Services such as developing individualized case plans, coordinating service referrals and monitoring service delivery are all targeted case management activities that are also essential elements of supportive housing.

*The Personal Care or Personal Attendant* option allows states to provide hands-on, direct assistance services to help individuals with everyday activities. Many people living with disabilities need these services to avoid institutionalization. Providers can furnish these services in a person’s own home, including a Permanent Supportive Housing unit, or in a Medical Respite Care program.

#### Suggested State Activities

To improve access and outcomes for enrollees who are chronically homeless or have had unstable housing experiences, States can begin by taking inventory of current Medicaid benefits and identifying and locating vulnerable individuals.

Medicaid utilization data and Homelessness Management Information System (HMIS) can work together. Understanding current capacity and assessing gaps will suggest immediate interventions and support future planning efforts aimed at system rebalancing. The following are illustrations for working with existing data sources:

- By relating Medicaid and Homelessness Management Information System (HMIS) data (to the extent feasible), Medicaid officials can quantify, profile and geographically map subpopulations with high costs, needs and utilization rates.
- Analysts can supplement Medicaid data with other relevant public health information to determine if existing Medicaid service options are aligned with the needs of these subpopulations. Depending on findings, administrators can design appropriate outreach efforts and seek needed waivers and plan amendments.

Once these assessment data are understood, States can begin to determine how well Medicaid is currently positioned to meet the needs of enrollees in supportive housing and those who frequently access housing assistance programs. This information can be organized and disseminated to educate providers about the needs of chronically homeless enrollees, and the services that are already Medicaid reimbursable. As important, “crosswalking” the data as suggested will reveal the coverage gaps that can be addressed through state plan changes, waiver requests or general health reform implementation.

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Beyond programmatic changes, state Medicaid officials should consider proactively engaging hospitals, FQHCs, behavioral health clinics, and homeless assistance leaders, particularly in urban areas where housing and public health safety nets are heavily burdened. This local collaboration can result in immediate interventions for identified populations, such as PSH placements and development of person-centered care plans matched with access to services.

Finally, Medicaid agencies are strongly encouraged to adopt appropriate strategies for chronically homeless populations in all plans for implementation of the Affordable Care Act and in ongoing HCBS efforts. Priority should be given to:

- Offering essential health benefits and designing enrollment strategies that will assure access to appropriate health care and supportive services for chronically homeless people and others at risk of homelessness because of high-health care needs. Enrollment systems should be able to rigorously evaluate vulnerable adults according to reliable disability and severity screens *before* considering assignment into essential health benefits ACA implementation also presents an opportunity, through Medicaid (and Exchange) systems, to collect data on applicants' housing stability so that at-risk enrollees can be assigned to a health care home with appropriate capabilities (e.g., a special populations health center such as HCH, etc.).
- Building capacity and establishing standards for Medicaid health homes so that community-based expertise in serving homeless people is fully utilized and compensated.
- Obtaining and analyzing data for targeting homeless populations for appropriate HCBS programs under 1915(i).

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<sup>1</sup> Agency for Healthcare Research and Quality. 2008. National and regional estimates on hospital use for all patients from the HCUP Nationwide Inpatient Sample (NIS). Available at: <http://hcupnet.ahrq.gov/HCUPnet.jsp>.

<sup>2</sup> Salit SA, Kuhn EM, Hartz AJ, Vu JM, Mosso AL. 1998. Hospitalization costs associated with homelessness in New York City. *New England Journal of Medicine*, 338 (24): 1734-40.

<sup>3</sup> Kertesz, S.G., Posner, M.A., O'Connell, J.J., Swain, S., Mullins, A.N., Shwartz, M., and Ash, A.S. 2009. Post-hospital medical respite care and hospital readmission of homeless persons. *Journal of Prevention & Intervention in the Community*, 27(2), 129-142.

<sup>4</sup> Buchanan, D., Doblin, B., Sai, T., & Garcia, P. 2006. The effects of respite care for homeless patients: A cohort study. *American Journal of Public Health* 96(7), 1278-1281.

<sup>5</sup> The National Alliance to End Homelessness maintains a database of 10-year plans, and monitors progress in selected localities. See <http://www.endhomelessness.org>.

<sup>6</sup> Falik M, et al. "Comparative Effectiveness of Health Centers as Regular Source of Care." January - March 2006 *Journal of Ambulatory Care Management* 29(1): 24-35.

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