

# MEDICAID'S HOME AND COMMUNITY-BASED SERVICES PROGRAM:

## AN ORIENTATION FOR HOMELESS HEALTH CARE PROVIDERS

POLICY & PRACTICE BRIEF

May 2012

Because funding for housing, health, and supportive services is often inadequate to meet the needs of people experiencing homelessness, service providers must explore all options available, including services available through their State's Medicaid program. Most homeless service providers are well-aware of targeted health and human service grant programs that benefit populations (e.g., SAMHSA mental health and addictions block grant funds, HRSA Ryan White and health center grants, etc.), but when it comes to the Medicaid programs, options are often complex and hidden in a matrix of Medicaid rules that many do not understand and are not explicit. Even State Medicaid agencies may not be taking advantage of all the available options. Hence, the flexibility afforded to States under Medicaid can be under-utilized.

The Medicaid expansion in 2014 to most people earning at or below 133% of the federal poverty level (FPL) will make nearly all people who are experiencing homelessness eligible for Medicaid. While health insurance coverage is a significant step towards improved health and wellness for people who lack housing, the actual benefits provided in each State's Medicaid plan for those who are newly eligible will be left largely up to States. While some States will choose robust Medicaid plans, others may adopt leaner packages. Unfortunately the law only requires certain categories of services to be covered, and does not include certain services (e.g., case management, home health) that are needed by low-income populations who would benefit from such assistance in order to maintain health and housing stability. Rather than making these services available to all Medicaid beneficiaries, which can be cost-prohibitive, States have the option to tailor or expand some services to targeted populations by requesting waivers or amendments to State Medicaid plans. One such option available to states is the Home and Community-Based Services Program, which provides access to a number of health-related services aimed to assist individuals who need these services to live independently at home or in a community-based setting. As such, homeless service providers should become familiar with their State's HCBS program as a potential resource for providing additional services to their clients.

This policy and practice brief will briefly describe the HCBS program, help homeless service providers understand how this program can be used to meet the needs of the people they serve, describe how to enroll people experiencing homelessness into this program, describe the access challenges often encountered, and offer recommendations to advocate for broader coverage for States that have strict HCBS eligibility criteria. This brief also highlights two examples of States that have applied HCBS to services of particular assistance to those experiencing homelessness.

### ABOUT THE HOME AND COMMUNITY-BASED SERVICES PROGRAM

Medicaid is the primary source of funding for nursing home care and long-term care services overall. In 1981, Congress created the Home and Community-Based Services Program to address the rising cost of institutional care and to provide an option for people to live more independently in the community. When the program was established, Medicaid beneficiaries had to demonstrate that they qualified for institutional care (require the level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded) in order to access

**NATIONAL HEALTH CARE FOR THE HOMELESS COUNCIL**  
P. O. Box 60427 | Nashville, TN 37206 | [www.nhchc.org](http://www.nhchc.org) | 615.226.2292  
Health Care and Housing Are Human Rights

NATIONAL  
HEALTH CARE  
for the  
HOMELESS  
COUNCIL

Medicaid reimbursable home and community based services. Most State HCBS programs continue to maintain this requirement; however, new options are now available to States to broaden HCBS coverage to people before they need institutional care and to individuals diagnosed with a mental health and substance use disorders.<sup>1</sup>

Though nearly all States have a HCBS program in place, the program is available as a State option and is not a requirement for participating in the federal Medicaid program. States that choose to provide HCBS services are eligible to receive federal matching funds [known as “Federal Financial Participation” (FFP)], to help support their programs. Each State’s approved HCBS plan and its details are integrated into the State’s Medicaid plan (usually available from each State’s website).

The most commonly adopted HCBS program is the 1915(c) waiver program which allows States to provide home and community based services to individuals who would otherwise require institutional care reimbursable by Medicaid. Because nearly all States have at least one 1915(c) HCBS waiver program in place, homeless service providers should learn how services available through this program might benefit qualified individuals who are experiencing homelessness. Another HCBS program that homeless service providers should understand is the 1915(i) State Plan HCBS program. While the 1915(i) State Plan HCBS program is less utilized by States, it has a unique applicability in serving individuals who do not yet qualify for institutional care and can be tailored to meet the needs of targeted populations, including people who are experiencing homelessness. Both the 1915(c) and the 1915(i) HCBS programs are described in more detail below.

### **1915(c) Home and Community Based Services Waivers**

Established in 1981, Section 1915(c) of the Social Security Act allows States to provide home and community based services to Medicaid beneficiaries who qualify for institutional level of care and receive Federal Financial Participation. The Act describes institutional settings as inpatient hospital services, nursing facility services, or services in an intermediate care facility for the mentally retarded. Services available through this program include case management, homemaker/home health aide, personal care, adult day health, habilitation, caregiver respite, and any other services requested by the State for day treatment or partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness.

In order to implement a 1915(c) HCBS program and receive FFP, a State’s Medicaid agency must demonstrate cost neutrality (meaning that HCBS services cannot cost more than institutional level care) and submit an application for a waiver to the federal Centers for Medicare and Medicaid Services (CMS) for consideration and approval.

States may tailor services to meet the needs of a particular target group. Within these target groups, States are permitted to establish additional criteria to further target the population to be served under the 1915(c) program (e.g. target by age or diagnosis such as autism, epilepsy, cerebral palsy, traumatic brain injury, HIV/AIDS; etc.). All but three States (Rhode Island, Vermont, and Arizona) have 1915(c) programs in place, each having different degrees of services and eligibility requirements. The Kaiser Commission on Medicaid and the Uninsured releases annual data updates of State HCBS programs, including the types of HCBS waiver programs that are in place to assist targeted populations, the numbers of people served in each waiver program, and the cost of care under each program.<sup>2</sup> This data can be helpful in preparing providers for discussions with decision makers when advocating for HCBS program expansion.

### 1915(i) State Plan Home and Community Based Services

The 1915(i) HCBS program was established with the enactment of the Deficit Reduction Act of 2005. It differs from the 1915(c) program in that individuals are not required to meet an institutional level of care to qualify for services. To qualify for services and supports under this option, people must meet State-defined criteria based on need and typically get a combination of acute-care medical services (like dental services, skilled nursing services) and long-term services (like caregiver respite, case management, supported employment and environmental modifications).

The Patient Protection and Affordable Care Act (ACA) improved the 1915(i) HCBS program by giving States more flexibility to target HCBS benefit packages to specific populations – for example – a benefit package could be created for people experiencing homelessness and in need of supportive services in housing (see the State example for Louisiana). States can also propose that additional services be covered beyond the traditional set of Medicaid home and community-based services (i.e., those available under the 1915(c) HCBS program) or create a new Medicaid eligibility category for people who are eligible for the State’s 1915(i) program, which would not only allow uninsured individuals to receive 1915(i) services but would also make them eligible for the full Medicaid package.

Unlike the 1915(c) HCBS program where States must submit an application for a waiver, States need only submit a State Medicaid plan amendment to implement the 1915(i) HCBS program. As such, the process for States to implement the 1915(i) program is more streamlined and allows States more flexibility in shaping their program. Figure 1 compares these two options.

Figure 1: Eligibility and Services under Two Federal HCBS Options

	1915(c) HCBS Waiver	1915(i) HCBS State Plan
Eligibility	Eligible individuals must demonstrate the need for a Level of Care that would meet the State’s eligibility requirements for services in an institutional setting.	States may provide services and supports before individuals need institutional care, and to individuals with mental health and substance use disorders.
Services	<ul style="list-style-type: none"> <li>• Case management</li> <li>• Homemaker/home health aide services and personal care services</li> <li>• Adult day health</li> <li>• Habilitation</li> <li>• Caregiver respite care</li> <li>• Any other services requested by the State for day treatment or partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness</li> </ul>	<ul style="list-style-type: none"> <li>• Same services as the 1915(c) HCBS program</li> <li>• Such other services requested by the State upon approval by the Secretary of the U.S. Department of Health and Human Services (excluding room and board)</li> </ul>

### ***A Brief Mention of Other 1915 Waiver programs***

While this brief focuses on HCBS programs established under Sections 1915(c) and 1915(i) of the Social Security Act, there are also HCBS programs that assist with personal assistance and attendant services. Section 1915(j), Self-Directed Personal Assistance Services Under State Plan Option, allows states to amend their State Medicaid plans to provide limited self-direction options for personal assistance services. This option allows individuals to purchase and manage personal assistance and related services, which are linked to a to established service plans.<sup>3</sup>

Section 1915(k), the Community First Choice Option, allows States to offer specific populations attendant services that help with basic living skills (such as dressing, bathing, food shopping) as a way of increasing independence as an individual transitions from a nursing facility, institution for mental diseases, or intermediate care facility for the mentally retarded to a community setting. Both the (j) and (k) options are typically directed at seniors and individuals with disabilities who are exiting institutional level care. While they may be applicable in some circumstances to individuals experiencing homelessness, it is more likely the 1915 (c) and (i) HCBS programs described above would have wider application to homeless health care providers.

### **DETERMINING ELIGIBILITY AND ENROLLING PATIENTS IN HCBS PROGRAMS**

Eligibility for HCBS services is determined by a State agency (or designee). In many States, local aging and disability agencies have mechanisms in place to help enroll people in an HCBS program. Homeless service providers should check their States' websites for checklists or fact sheets that provide detailed information about eligibility and services.

Homeless service providers can learn a lot about how the people they serve qualify for the HCBS program by contacting the agency responsible for eligibility and enrollment. While specific agencies or designees are responsible for formally determining eligibility and for enrollment, homeless health care providers can improve access to the program by incorporating practices to identify people who might be eligible for the HCBS program, ensuring adequate documentation to make the case for eligibility, and by making referrals to appropriate agencies.

### **THE PROVISION OF HCBS SERVICES**

HCBS services are delivered by State and local health and human service agencies or contracted out to organizations that specialize in the delivery of such services. In many States, Medicaid providers can submit an application to provide HCBS services. Online applications are generally available on States' websites. Once a Medicaid beneficiary is enrolled in the HCBS program, one or more providers will be assigned to the beneficiary by the administering agency in order to carry out the services needed in order to meet their individualized care plan.

### **CHALLENGES TO ACCESSING HCBS PROGRAMS BY PEOPLE EXPERIENCING HOMELESSNESS**

People experiencing homelessness face unique challenges in accessing home and community based services under State HCBS programs. These challenges include lack of health insurance, lack of housing, and more limited outreach and enrollment efforts.

#### ***Lack of health insurance***

Generally, the HCBS program is only available to Medicaid beneficiaries. States may choose to provide HCBS services to people who are uninsured, but this would be at 100% State expense since federal funding would not be available for this population. Unless individuals experiencing homelessness live in a State that has opted to expand

Medicaid to low-income individuals prior to 2014, they must meet other Medicaid eligibility criteria (e.g., children, very low-income parents, and seniors, or individuals with disabilities) in order to receive HCBS services).

Only 25% of people experiencing homelessness who are patients of federally qualified health centers were insured through Medicaid in 2010.<sup>4</sup> In 2014, when Medicaid expands to include 16 million adults without dependent children earning at or below 133% of the FPL, many of those experiencing homelessness will become eligible for Medicaid. With large numbers of people who have chronic and disabling conditions (but have not yet attained federal disability status) experiencing homelessness, States should consider opportunities to increase outreach and Medicaid enrollment opportunities for this population and how to best link individuals to home and community based services. States should also ensure the package of services they are planning for the newly eligible Medicaid population is sufficient to meet the health care needs of this new group since HCBS services may not be automatically included in the new benchmark plan.

### **Lack of housing**

As its name implies, the HCBS program provides services and supports to people in their homes or in community-based settings as an alternative to institutionalized care. For homeless Medicaid beneficiaries who are able to access housing, the HCBS program can be reimbursable means of providing supportive services such as assertive community treatment (ACT) and intensive case management (ICM).

Housing reforms authorized under the Frank Melville Supportive Housing Investment Act of 2010 aim to improve housing placement for people who have disabilities. The Act includes incentives that are expected to add thousands more Section 811 units to housing developments. Additionally, new Section 811 project selection criteria emphasize locations that “facilitate the provision of community-based supportive services and address other basic needs.”<sup>5</sup> The Act also improves HUD’s Rental Assistance for Non-Elderly Persons with Disabilities (NED) Program by mandating that all housing choice vouchers dedicated to NED families remain with NED families to the maximum extent possible. While housing reforms authorized under the Frank Melville Supportive Housing Investment Act will create additional housing opportunities for low-income individuals and families who have disabilities, many communities will continue to struggle to provide housing to all who need it. To better address housing needs for people who would otherwise be eligible for home and community-based services, Iowa established a rental subsidy program for HCBS beneficiaries which is described in more detail below.

### **Limited outreach and enrollment**

Applications for HCBS services are often facilitated by State health and human service agencies or contracted out to local aging and/or disability resource groups (e.g., Aging and Disability Resource Centers, Area Agencies on Aging and Disability). These agencies and homeless service providers are generally not in the same local service networks, but States can encourage systems to work more closely together. For example, Louisiana’s HCBS program, which is described in more detail below, explicitly integrates their HCBS program into its Permanent Supportive Housing (PSH) program.

Homeless service providers, particularly those who are engaged in health and housing services, should meet with their State HCBS representative to discuss outreach and enrollment opportunities for people experiencing homelessness. Outreach and enrollment could target individuals who meet State HCBS eligibility criteria and are living in targeted housing programs for people experiencing homelessness or waiting for housing to become available in order to ensure immediate access to the HCBS program.

## RECOMMENDATIONS TO IMPROVE ACCESS TO STATE HCBS PROGRAMS BY PEOPLE WHO ARE EXPERIENCING HOMELESSNESS

- **Meet with your State's HCBS lead and learn about your State's HCBS programs.** With each State having its own unique HCBS program, it is important for homeless service providers to learn how these programs can benefit the people they serve. Learn which services are offered as part of the HCBS program and who is eligible to participate. States have considerable flexibility in shaping their HCBS programs. If your State's HCBS program does not meet the needs of your clients, consider scheduling a meeting with a representative from your State Medicaid office to discuss the needs of your clients and how the HCBS program can include people experiencing homelessness who are at risk of institutionalization.
- **Learn how to enroll patients in HCBS programs.** In most communities, homeless health care providers are not well integrated into the HCBS system. As such, it is important to learn who in your community is responsible for enrollment and developing care plans. As a primary health care provider for patients experiencing homelessness, health centers can be instrumental in providing needed documentation for proof of eligibility, help patients better understand how the HCBS program can meet their needs, and make any necessary referrals.
- **Encourage your community to prioritize housing for people who have disabilities.** Many communities have conducted vulnerability risk assessments to prioritize housing for those who have significant disabilities or at highest risk of early mortality due to chronic illness. Once in housing, the HCBS program can be used to bring supportive services to individuals in their homes freeing up other supportive housing funding streams. Providers can also encourage entities responsible for developing local or State vulnerability risk assessments to include criteria that matches HCBS assessment criteria.
- **Become a HCBS provider.** In some States, Medicaid providers can apply online to become a HCBS provider. Some current HCBS providers may not have the skill sets needed (or the interest) to serve the unique needs of people who are experiencing homelessness. Health Care for the Homeless projects are uniquely positioned to serve the health care needs of people experiencing homelessness. Becoming a HCBS provider can ensure quality and continuity of care for people experiencing homelessness.
- **Collaborate with HCBS providers.** If becoming an HCBS provider isn't a feasible option, collaborate with HCBS providers by offering educational sessions about the unique aspects of homelessness that will impact the provision care they deliver or schedule case reviews to discuss opportunities to improve care coordination.
- **Advocate for your patients.** In States where HCBS eligibility criteria excludes patients who could benefit from the HCBS program, meet with your State Medicaid agency to discuss opportunities to amend the State's HCBS program to be more inclusive [possibly using the 1915(i) program described previously]. A strong case can be made for cost savings particularly as people experiencing homelessness begin enrolling in State Medicaid programs in 2014 (or earlier at State option). Many States assert that State funds are already being used to provide supportive services in housing; by financing these services through the HCBS program, States can receive a federal match thus freeing up State funds to serve more people.

## STATE EXAMPLES

### **Louisiana: Combining Programs, Lowering Costs<sup>6</sup>**

Louisiana's 3,000-unit Permanent Supportive Housing (PSH) Program is the nation's first large-scale cross-disability, integrated PSH initiative to include sustainable funding for both housing and supportive services.

Louisiana created a highly centralized, State policy driven system which targets all of the State's PSH priority populations, including people with disabilities who are either homeless or at-risk of homelessness and people living unnecessarily in institutions [through the 1915(c) and other waivers] or at-risk of institutionalization [through the 1915(i) waiver].

Louisiana's PSH approach requires that new local PSH services infrastructure be developed to manage outreach, referral, and service coordination functions. The State's Department of Health and Human Services (DHH) initially designated six entities to serve as Local Lead Agencies (LLAs) responsible for managing these activities. These LLAs are local human service authorities responsible for mental health, substance use and developmental disabilities services, or regional DHH program offices responsible for either mental health or aging and adult services. LLAs and local service providers received extensive training and technical assistance to ensure consistent service model implementation and to develop the staff skills and knowledge necessary to assist persons to get housing, utilize services, and achieve stable housing and recovery. The LLA responsibilities will become the responsibility of the new Statewide Managed Care organization (SMO), Magellan Health Services, in 2012.

DHH elected to contract with a SMO to manage Medicaid and State-funded behavioral health services. Having one program structure managing services for all disability groups ensures greater coordination and accountability while making the program widely available across the State.

To make the case for HCBS coverage for the PSH population, DHH conducted reviews to analyze the demographics, types of benefits, and potential service and support needs of individuals being made eligible for PSH. These reviews revealed that over 80% of the tenants are likely to be eligible for Medicaid, and the majority of tenants will have behavioral health services needs. Additionally, a significant number of individuals were found to be eligible for HCBS because they either have an intellectual disability or qualify for long-term care. The reviews also revealed a significant overlap between the interventions individuals were receiving in the PSH program and services included or proposed in the Medicaid State Plan and HCBS Waivers.

Their assessment led to a modification of the PSH program design to enable DHH to sustain the program with a minimum investment of limited State resources. This design includes: (1) an updated governance structure for planning, policy setting, budgeting, managing, monitoring and reporting on performance and outcomes. A PSH Executive Management Council was named in 2011 with representation from the Louisiana Office of Community Development, DHH, the State's Medicaid Director, Assistant Secretaries of Behavioral Health, Developmental Disabilities and Aging and Adult Services, and PSH management staff; (2) a management structure to permit DHH to conduct outreach, eligibility determination, services assignment, tracking and reporting, support for tenant-landlord liaison services and management of contingency funds for move-in assistance; and (3) PSH services interventions embedded into key Medicaid coverable services, and services coverage for individuals not eligible for the Medicaid services with included interventions.

PSH interventions are now embedded into Assertive Community Treatment (ACT), Intensive Case Management (ICM) and Community Psychiatric Support and Treatment (CPST) services covered in the State's Medicaid program. This was made possible through a 1915(i) Medicaid State Plan amendment in 2011. PSH service interventions will also be combined into other multiple HCBS programs. Service arrangements will be made with substance abuse service providers in the near future.

To date, the program has provided housing for over 2,500 of the most vulnerable people with disabilities across Louisiana's Gulf Coast region. Housing retention rates are high and average monthly Medicaid costs per person have been reduced. State and federal housing and human service officials; national, State, and local homeless and disability advocates; PSH experts; philanthropy and local service partners each played a critical role in this success.

**Iowa: Housing as Bridge to Health Care<sup>7,8</sup>**

Iowa operates six HCBS waivers targeting people who are aged, ill, disabled, diagnosed with HIV/AIDS, have an intellectual disability, and those diagnosed with a brain injury. Recognizing that many people who would benefit from HCBS services also lack housing, particularly when exiting an institution, Iowa created a 100% State-funded rental subsidy program to assist people in accessing housing while receiving HCBS services. While the rental subsidy program is not part of the federally supported HCBS program, these funds allow access to HCBS services for those who qualify but lack housing. The rental subsidy program is managed by the Iowa Finance Authority.

Individuals must first demonstrate eligibility for the HCBS program before becoming eligible for the rental subsidy. To be eligible for HCBS, individuals must demonstrate the need for nursing facility level of care (at a minimum). Once eligibility for HCBS has been determined, individuals are assessed for eligibility to receive a rental subsidy. Rental subsidies are available to people who have insufficient funds to pay their community housing costs and as such are at risk of placement into a long term care facility. Individuals eligible for a rental subsidy must provide evidence that they will pay 30% of their gross income for rent and that they are not currently receiving (or eligible for) other rental assistance. A minimum contribution of \$25 per month toward the cost of rent is expected from all applicants.

Eligible beneficiaries who lack housing are required to apply for Section 8 housing prior to receiving the State subsidy. While waiting for Section 8 housing to become available, the State provides the beneficiary a subsidy based on a monthly payment calculation rate (see figure 2). Individuals receiving rent subsidy are encouraged to select an apartment that accepts Section 8 vouchers to eliminate the need to move once the voucher becomes available.

Figure 2: Formula for determining the rental subsidy

Process	Factor	Notes
Start with	Whichever is less: Actual rent <b>OR</b> 110% x Fair Market Rent	
Divide by	Number of bedrooms	One bedroom or proportionate share of a rental unit with more than one bedroom (exception can be made for a qualified dependent relative)
This equals	Allowable rent + number of bedrooms	The proportionate rent allowed for a single person
Multiply by	Proportionate rent x (applicant + dependents)	
This equals	Adjusted proportionate rent	
Subtract	Gross monthly income x 30%	30% of income is a required contribution towards rent
The remainder	Amount of rent subsidy	

**CONCLUSION**

With constrained budgets and an overwhelming demand for housing and supportive services, providers must become familiar with all potential avenues of funding. Medicaid’s Home and Community Based Services program continues to be an underutilized resource for providing important supportive services to people experiencing homelessness. Two reasons for underutilization are a lack of awareness of this option among homeless service providers, and infrequent communication between these providers and State Medicaid representatives responsible for administering the State’s HCBS program.

Homeless service providers can improve access to HCBS for people experiencing homelessness by adopting practices to identify individuals who are potentially eligible for their States' HCBS program, and by ensuring adequate documentation in client or patient records to demonstrate eligibility. Additionally, providers can increase collaborations with local entities responsible for HCBS enrollment and decision making in order to ensure appropriate referrals and increase awareness of the unique long-term care needs of people experiencing homelessness.

With many States maintaining strict eligibility requirements, providers should also advocate for more inclusive participation in existing State HCBS programs and describe the need for adopting a targeted 1915(i) HCBS program for people experiencing homelessness if a program has yet to be adopted. By understanding the scope of federal HCBS programs, homeless service providers can help their State Medicaid representative understand how the HCBS program can be tailored to support homeless service initiatives.

As a primary source of health care for people experiencing homelessness, Health Care for the Homeless (HCH) grantees are well positioned to advocate for the health and service needs of the people they serve. Data describing the long-term care needs of HCH patients (and the costs related to not providing these services) can be tremendously helpful in helping State administrators understand how the HCBS program can be better utilized. By improving access to HCBS services, using other States as examples, and approaching these options with an innovative eye, new opportunities will emerge to improve the health and housing stability for people experiencing homelessness.

### REFERENCES

---

- <sup>1</sup> Centers for Medicare and Medicaid Services. (August 6, 2010). Improving Home and Community-based Services. Retrieved from <http://www.hhs.gov/od/topics/community/iathcbssmd8-6-102.pdf>
- <sup>2</sup> Kaiser Commission on Medicaid and the Uninsured. (2011). Medicaid home and community based services programs: Data update. Retrieved from <http://www.kff.org/medicaid/upload/7720-05.pdf>
- <sup>3</sup> Centers for Medicare and Medicaid Services. (November 19, 2009). Dear State Medicaid Director Letter. Retrieved from <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD111909.pdf>.
- <sup>4</sup> Health Resources and Services Administration. 2010 Uniform Data System: Selected patient characteristics. Retrieved from <http://bphc.hrsa.gov/uds/socioeconomic.aspx?year=2010&state=&prog=HO>
- <sup>5</sup> Technical Assistance Collaborative. (January 7, 2011). Frank Melville Supportive Housing Investment Act of 2010 Reforms to HUD's Section 811 Program Enacted: Summary. Retrieved from [http://811resourcecenter.tacinc.org/media/775/tac\\_summary\\_811\\_programreforms.pdf](http://811resourcecenter.tacinc.org/media/775/tac_summary_811_programreforms.pdf)
- <sup>6</sup> *Information taken from:* Technical Assistance Collaborative. (February 2011). Taking integrated permanent supportive housing (PSH) to scale: The Louisiana PSH Program. Available from the Technical Assistance Collaborative, [www.tacinc.org](http://www.tacinc.org)
- <sup>7</sup> C. Pope (personal communication, January 13, 2012)
- <sup>8</sup> Iowa Housing Finance Authority. HCBS rent subsidy program. Retrieved from [http://www.ifahome.com/en/for\\_renters/hcbs\\_rent\\_subsidy\\_program/](http://www.ifahome.com/en/for_renters/hcbs_rent_subsidy_program/)

Suggested Citation: National Health Care for the Homeless Council. (May 2012.) Medicaid's Home and Community-Based Services Program: An orientation for homeless health care providers. (Lead author: Sabrina Edgington, Policy and Program Specialist.) Retrieved from: [www.nhchc.org/wp-content/uploads/2011/10/HCBS-Policy-Brief.pdf](http://www.nhchc.org/wp-content/uploads/2011/10/HCBS-Policy-Brief.pdf)

This publication was made possible by grant number U30CS09746 from the Health Resources and Services Administration, Bureau of Primary Health Care. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of HRSA.