



SEPTEMBER 2015

# Improving Care for Medicaid Beneficiaries Experiencing Homelessness: Handout #2 - for state agencies, health plans, and health care providers

## UNDERSTANDING THE HOMELESS ASSISTANCE SYSTEM

There are many different supportive housing and homeless assistance programs across the country. The availability and types of programs vary from one state or region to another. This can make it challenging to know where to start, but it's worth the effort to make and sustain connections to local homeless assistance systems and programs to leverage resources they have to offer to Medicaid beneficiaries who are experiencing homelessness.

Linking Medicaid beneficiaries to housing assistance can have a big impact on reducing avoidable emergency room visits and hospitalizations and improving health outcomes – particularly for people who have chronic health conditions, co-occurring behavioral health conditions, and other vulnerabilities.

*For more information about Permanent Supportive Housing see: Handout #1*

### Permanent Supportive Housing for Homeless People

A **Continuum of Care** (CoC) is a regional or local planning body that coordinates housing programs and other assistance for people who experience homelessness, consistent with requirements and incentives associated with federal funding from the U.S. Department of Housing and Urban Development (HUD). Each CoC is responsible for developing a community plan to meet the needs of people who are homeless, and for submitting a single, coordinated application for federal funding for HUD's homeless assistance programs.

In January 2015 HUD announced \$1.8 billion in grant finding for CoC homeless assistance programs, including \$45 million for new permanent supportive housing to serve homeless people with disabilities.<sup>1</sup> In recent years, federal funding allocated through the CoC has prioritized permanent supportive housing projects that serve people who are **chronically homeless**. Most states have more than one CoC, but a few states have a single statewide CoC. Most major cities and/or counties with significant population have a CoC, but some regional CoCs include multiple jurisdictions. Most states have a "Balance of State CoC" that includes parts of the state that are not included in local CoCs.

## ABOUT STATE HEALTH AND VALUE STRATEGIES

State Health and Value Strategies, a program funded by the Robert Wood Johnson Foundation, provides technical assistance to support state efforts to enhance the value of health care by improving population health and reforming the delivery of health care services. The program is directed by Heather Howard at the Woodrow Wilson School of Public and International Affairs at Princeton University. For more information, visit [statenetwork.org](http://statenetwork.org).

## ABOUT THE ROBERT WOOD JOHNSON FOUNDATION

For more than 40 years the Robert Wood Johnson Foundation has worked to improve the health and health care of all Americans. We are striving to build a national Culture of Health that will enable all Americans to live longer, healthier lives now and for generations to come. For more information visit [www.rwjf.org](http://www.rwjf.org). Follow the Foundation on Twitter at [www.rwjf.org/twitter](http://www.rwjf.org/twitter) or on Facebook at [www.rwjf.org/facebook](http://www.rwjf.org/facebook).

**Carol Wilkins, MPP** is a nationally recognized expert on integrating health care, social services, and housing assistance for persons with disabilities, with a focus on persons who experience homelessness. She conducts research and provides technical assistance to develop and support the implementation of evidence-based policy solutions for people with complex health needs and vulnerabilities. She has worked with several states to support the use of Medicaid financing and delivery systems to provide the services and supports needed for homeless people with complex health needs to get and keep housing, and to reduce avoidable hospitalizations and other costs.

To find the Continuum of Care contacts for your state or community,

- You can use the link below. Use the drop-down menus to find your state and select a program CoC: Continuum of Care Program. Each CoC is identified with the abbreviation for the state name, a number, and the CoC name. For example, GA-500 is Atlanta County.

<https://www.budexchange.info/grantees/?grantaction=main.searchresults&programid=3>

- You can also use this link:

<http://portal.hud.gov/budportal/HUD?src=/states>

and select your state. When you get to the page for your state, look under **I want to** and click on **Find Homeless Resources**. This may take you to a web page that includes Continuum of Care contact information.

- You can also try searching the web for Continuum of Care (insert the name of your state, county, or major city)

Each Continuum of Care is responsible for maintaining an inventory of permanent supportive housing, as well as emergency shelters and transitional housing programs that serve homeless people. You can find the most recent Housing Inventory Reports for a state or a CoC at this link:

<https://www.budexchange.info/manage-a-program/coc-housing-inventory-count-reports>

For **homeless people with serious mental illness**, additional housing and service options are often available through the publicly funded mental health or behavioral health system. In many states, Medicaid benefits for mental health or behavioral health benefits are “carved out” from other Medicaid benefits and administered separately by other state agencies or departments. Behavioral health services are often funded by a combination of Medicaid reimbursements and other sources of state, local, and federal funding. In some states, county governments play important roles in managing the delivery of behavioral health services.

Many states and counties have used some of the resources in their mental health or behavioral health systems to invest in creating supportive housing, paying for rent subsidies, and/or paying for supportive services that are matched with housing resources funded from other sources. For example, a

state or county may provide funding to a contracted provider to deliver case management services for homeless people with serious mental illness, and these services may help consumers use housing vouchers that are administered by a local public housing authority. In order to access housing options available through the mental health system, a Medicaid beneficiary usually must have some connection to mental health services. Some of these services may be specifically designed to engage hard-to-reach homeless people with serious mental illness and co-occurring substance use disorders.

- Ask the state or county mental health (behavioral health) department about services that fund outreach and services for homeless persons with mental illness. Some of these services are designed to engage and support people with serious mental illness and co-occurring substance use disorders who have experienced or are at risk of hospitalizations, homelessness, or involvement in the criminal justice system. These programs may be intended to serve people who have not been effectively engaged in and served by other types of treatment programs.
- Ask if the mental health (behavioral health) department has a housing coordinator or a contact person for housing, or if some of mental health system’s services are connected to housing resources. Many states and counties have used the resources of their mental health (behavioral health) system to create permanent supportive housing, sometimes through collaborations with state housing finance agencies and nonprofit developers of affordable rental housing. Some programs provide the services that help homeless people use housing resources that are administered by a Continuum of Care or local public housing authority (PHA).
- Medicaid providers and care managers can ask a consumer if he or she is already receiving mental health services, and if they can contact the mental health service provider, with the consumer’s consent, to better coordinate care and help to facilitate access to housing assistance.

For **homeless people who have served in the U.S. military**, housing assistance (vouchers) and supportive services may be available through the HUD-VA Supportive Housing (VASH) program, which is implemented through partnerships that involve VA Medical Centers and local public housing authorities. Another program, Support Services for Veteran Families (SSVF) provides time-limited financial assistance and

case management services for veterans who are homeless or at risk of homelessness. Because federal funding has supported a major expansion in programs for homeless veterans over the past few years, housing assistance is likely to be available for eligible veterans. To help veterans and their family members connect with local housing and service resources, call the National Call Center for Homeless Veterans 1-877-4 AID VET (1-877-424-3838)

**Coordinated Entry Systems** are being developed to streamline the process of connecting homeless people to supportive housing and other types of housing assistance, and to prioritize housing for those who are most vulnerable. Some of the most vulnerable and high-cost Medicaid beneficiaries are likely to be among the homeless people who will be prioritized for housing through coordinated entry systems. In most states and communities these systems, which are mandated as a condition of receiving federal funding through HUD's Homeless Assistance grants program, are very new or still in the planning stage.

Some communities are receiving help to develop and implement coordinated systems for outreach, assessment, and matching homeless veterans and chronically homeless persons to the most appropriate housing assistance. These national initiatives, which include the 25 Cities initiative and Zero: 2016, have received support from the federal government and private funders. For more information see <http://www.25cities.com> and <http://cmtysolutions.org/zero2016>.

As coordinated entry systems are implemented and expanded, the hope is that these systems will make it much easier and faster for homeless people to get the help they need. Coordinated entry systems will eliminate the need for people who are experiencing homelessness (or the care managers and service providers who are helping them) to make multiple calls and visits to housing and homeless assistance programs to find openings, or to get on multiple wait lists. These systems will also use more consistent approaches to matching people to the housing assistance for which they are eligible, and prioritizing people for housing based on their needs, using criteria that have been established with input from community stakeholders and partners. Medicaid providers and health plans may be able to provide input and support for the development and implementation of coordinated entry systems. If health care providers and care managers understand the criteria used to prioritize people for housing, they will be better able to assist some of their most vulnerable consumers.

## Other types of housing assistance and shelter programs for people experiencing or at risk of homelessness:

In addition to permanent supportive housing, there are other types of homeless assistance programs and services available in many communities across the country. Some of these programs offer emergency shelter, transitional housing, homelessness prevention, rapid re-housing, drop-in / day shelters, street outreach, and other types of services and housing assistance, which may be time-limited. For some people who are experiencing homelessness for the first time, or for a relatively short period of time, these time-limited programs may offer the help they need to get back into housing. For people with higher levels of vulnerability, and long-term or repeated episodes of homelessness, these programs may offer connections to permanent supportive housing or other assistance, particularly if they are linked to a coordinated entry system.

Many communities are working to make changes in the programs and strategies they are using, with the goal of allowing more people to get the help they need to quickly return to housing. Instead of encouraging homeless people to stay in shelters or transitional housing programs for many weeks or months, while they save money and engage in services such as drug counseling, parenting education, or job training, **rapid re-housing** programs focus on helping people get into rental housing quickly, with one-time or time-limited financial assistance to help pay rent, security deposits, moving costs, utilities, and other expenses. As people move into housing, the programs provide or link people to the supports they need to keep their housing, including help to increase their incomes and access health care, treatment, and other services in the community.

**Medical respite** or **recuperative care** programs are designed to provide a safe place for homeless people to stay, usually for a few weeks, when they are being discharged or diverted from a hospital. These programs often provide some nursing care or coordination with home health services and help to access appropriate follow-up care, as well as case management to connect homeless people to permanent housing and other ongoing services and supports. Medical respite programs are intended to serve people who do not need to remain in a hospital or skilled nursing facility, but they are too sick or vulnerable to return to the streets or a regular shelter setting. The National Health Care for the Homeless Council has developed a Medical Respite Toolkit <http://www.nhchc.org/resources/clinical/medical-respite/tool-kit/> and other resources, including proposed Minimum Standards for Medical Respite Programs <http://www.nhchc.org/resources/clinical/medical-respite>.

## Other housing resources and supportive housing programs:

In some communities, PHAs have established wait list preferences for people who are homeless. Sometimes these preferences are used to provide housing assistance to people with special needs (e.g. homelessness, disability, etc.) who are receiving services from other organizations. Some PHAs administer housing vouchers or programs that are designated for people with special needs, including people experiencing homelessness. If Medicaid benefits or health plans can pay for case management and other supportive services through

collaborations with community-based service providers, these resources can often leverage the housing resources administered by PHAs.

In a few communities, a local Health Department or the system that operates public hospitals is implementing programs that offer permanent and short-term housing options and medical respite / recuperative care for patients who are homeless. People who are being discharged from public hospitals and those who are frequent users of locally funded health services are likely to be prioritized for access to this housing.

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## Endnotes

<sup>1</sup> For a list of projects that received funding awards announced in January 2015 (FY2014), use this link to find your state. [http://portal.hud.gov/hudportal/HUD?src=/program\\_offices/comm\\_planning/homeless/budget/2014](http://portal.hud.gov/hudportal/HUD?src=/program_offices/comm_planning/homeless/budget/2014) Note that some projects in your state may have received multi-year funding awards in prior years, so this is not a complete list of all homeless assistance programs that are receiving HUD CoC grant funding.