Medicaid’s Home and Community-based Services Program: An Orientation for Homeless Health Care Providers

Thursday, May 31, 2012
We will begin promptly at 2 PM EST

Event Host: Sabrina Edgington
National Health Care for the Homeless Council

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Presenters

Marti Knisley
Director, Community Support Initiative, Technical Assistance Collaborative

Christine Rhorer
Housing/Homeless Coordinator, Louisiana Office of Mental Health

Carla Pope
Senior Project Coordinator, Iowa Finance Authority
Home and Community-Based Services

- Allows individuals to live more independently in a home and community-based setting (as opposed to an institution)
- Several different HCBS programs available to provide flexibility to states and to improve access to targeted populations
  - 1915(c) – Home and Community-Based Services Waiver
  - 1915(i) – State Plan Home and Community-Based Services
  - 1915(k) – Community First Choice
- FFP incentive for states offering HCBS to Medicaid beneficiaries
<table>
<thead>
<tr>
<th><strong>Eligibility</strong></th>
<th><strong>Services</strong></th>
<th><strong>State requirements/options</strong></th>
</tr>
</thead>
</table>
| 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. | • Case management  
• Homemaker/home health aide services and personal care services  
• Adult day health  
• Habilitation  
• Caregiver respite care  
• 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  
• States can also propose “other” types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community | • States must submit an application for a waiver  
• Must be “budget neutral” meaning waiver services won’t cost more than providing these services in an institution  
• Services follow an individualized and person-centered plan of care  
• States can waive statewideness to target waivers to areas of the state where the need is greatest, or where certain types of providers are available  
• States can waive comparability of services to make waiver services available only to certain groups of people who are at risk of institutionalization |
### 1915 (k) Community First Choice

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<th>State requirements/options</th>
</tr>
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</table>
| 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. Income of up to 150% FPL or higher if the state has a higher income threshold for Medicaid eligibility. | • Home and community-based attendant services and supports to assist with ADLs, instrumental ADLS, and health related tasks  
• Beneficiaries may self direct services (can hire and fire providers). Can hire family members.  
• States can cover transition costs  
• States can cover services that increase independence or substitute for human assistance | • States electing this option receive a 6% increase in their FMAP  
• States must make services available statewide, with no caps or targeting by age, severity of disability, or any other criteria  
• States must establish a Development and Implementation Council to collaborate on program design and implementation. The Council must have majority membership of the elderly, people with disabilities, or their representatives |
# 1915 (i) State Plan Home and Community-Based Services

<table>
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<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>States may provide services and supports before individuals need institutional care, and to individuals with mental health and substance use disorders.</td>
<td>• Case management</td>
</tr>
<tr>
<td>Income of up to 150% FPL; States the option to expand the program to include individuals eligible for a HCBS waiver who have incomes up to 300% of Supplemental Security Income (SSI).</td>
<td>• Homemaker/home health aide services and personal care services</td>
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<td></td>
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<td>• 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)</td>
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### State options

- States can disregard comparability in order to target individuals with specific diagnoses and conditions. (targeting criteria is different than needs-based criteria)

- States can elect to cover individuals who are otherwise not eligible for Medicaid but meet the state’s needs-based criteria for 1915(i) and meet the income criteria (up to 150% FPL)

- States can elect to offer state plan HCBS to individuals with income sup to 300% of the SSI/FBR if they meet the needs-based criteria under 1915(c), (d), (e) waiver or an existing 1115 demonstration waiver

- States can phase in their state plan HCBS to those with the highest needs but must enroll all eligible individuals within the first 5 years of the program.

- States can elect to include 1915(i) benefits as part of a managed care contract.
## 1915 (i) State Plan Home and Community-Based Services

<table>
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<tr>
<td>• 1915(i) HCBS needs-based criteria must be less stringent than the criteria for 1915(c) HCBS criteria</td>
</tr>
<tr>
<td>• States cannot limit the number of people receiving 1915(i) HCBS or create waiting lists (rather states can project numbers to be served and constrict needs-based criteria if numbers exceed projections)</td>
</tr>
<tr>
<td>• State quality assurance strategies will need to provide adequate supports for self-direction, which includes the availability of an independent advocate to assist the individual with access to and oversight of their HCBS.</td>
</tr>
<tr>
<td>• Independent Evaluation vs. Independent Assessment</td>
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Louisiana’s PSH Program: Overview

• Louisiana’s Home and Community Based Waiver and 1915(i) State Plan services are being made available to qualified recipients as part of the state’s Permanent Supportive Housing (PSH) Program.

• This program began as a major initiative in the state’s federally-funded Road Home hurricane recovery plan in 2007.

• The result to date is that over 2,400 individual households with a member with a substantial disability are receiving services and rent subsidies.
Louisiana’s PSH Program: Overview

- Louisiana has taken steps to assure this program can grow and be sustained with permanent federal rental subsidies and Medicaid and other federal, such as Ryan White or state funded services that are voluntary and individualized.

- This program was created by:
  - State housing & human service officials from the LA Department of Health & Hospitals (DHH), the LA Department of Children & Family Services (DCFS), the LA Office of Community Development (OCD) & the LA Housing Finance Agency (LHFA)
  - Homeless & disability advocates at the national, state & local levels
  - Local housing & service partners
  - Philanthropy (Melville, RWJF, Red Cross) & technical assistance (TAC) for policy & program development, capacity building & implementation support.
**Program Design**

- **State-level partnership** between housing & human service agencies to leverage mainstream affordable housing & services funding;

- **A replicable housing production strategy** that creates ‘scattered site’ units coupled with subsidies to make the housing affordable to extremely low-income households;

- Service entities designated by the state to provide local PSH infrastructure for outreach, referrals to housing, community-based PSH service delivery & relationships with landlords/owners;

- **A services sustainability** plan that embeds PSH requirements into Medicaid covered services; and

- **A formal targeting policy** that ensures a cross-disability population which includes people who are homeless/chronically homeless, institutionalized, or at risk of either gain access to housing & services.
State Level Partnership

The Office of Community Development (OCD) & the Department of Health & Hospitals (DHH) have a formal written cooperative agreement.

**OCD** has responsibility for overall PSH program administration to manage rental subsidies and allocate other housing resources including federal CDBG funding.

- **OCD** became the Louisiana Public Housing Authority (**LHA**) to administer housing subsidies tied to the program.

**DHH** is responsible for establishing a population targeting policy, local infrastructure for outreach, referral and supportive service delivery & and assuring sustainable services are available to service recipients across three consecutive tenancy stages, pre-tenancy, move in and post tenancy.
Governance

The state created an Executive Management Council to govern and set policy for this initiative.

This includes OCD-LHA Director and key staff at DHH: the DHH Deputy Secretary, Assistant Secretaries for Developmental Disabilities, Aging and Adult Services and Behavioral Health, the state’s Medicaid Director and the DHH PSH Program Director.
Initial Local PSH Management

• DHH originally designated six Local Lead Agencies (LLAs) to create local PSH capacity and infrastructure; each received an ‘allocation’ of PSH units based on housing loss in each region.

• LLAs managed outreach to all target populations & make referrals to PSH units, and contract with local service providers for the provision of PSH services: pre-tenancy, move-in & housing support/stabilization.

• Services requirements were based on the ‘Housing First’ philosophy:
  • Individually tailored & flexible
  • Focused on helping households get & keep housing
  • Leverage community-based services to meet tenant needs
  • Responds to periods of crisis or increased needs immediately
  • Training & capacity building provided to assure consistent service delivery & staff skills/knowledge to assist persons to get housing, utilize services, achieve their recovery goals & remain stably housed.
Initial PSH Infrastructure

• Each LLA tracked housing referrals and services assignments.

• Same tracking system captured demographic and eligibility information.

• The DHH PSH office was able to match this data with Medicaid program eligibility and service use data to verify program eligibility and service use and costs.

• DHH and OCD also able to establish performance benchmarks and measure program outcomes with program goals and objectives.

• DHH and OCD also built in processes for eligibility determination, re-determinations, waiting list management and tracking other requirements such as Shelter Plus Care match data.

• DHH built in an initial services payment contracting structure.
New PSH Management & Infrastructure

• In 2011-12 the DHH made changes in the scope and management of their Medicaid programs, adding 1915(i), 1115, 1915 (b) and 1915(c) programs and making changes in existing 1915(c) programs.

• PSH services interventions were added to several of these programs; other changes are in the works now to assure current and prospective tenants will get services they need to get and keep housing.

• The new DHH Behavioral Health Managed Care Organization (SMO) will take over what was the local LLA management responsibility for this program.

• This change was added to the SMO’s RFP and contract.
New PSH Management & Infrastructure

• The SMO is responsible for: outreach, screening, making referrals to the LHA, tenant services management, contingency fund management and tracking and reporting for all populations served.

• The SMO and each DHH office will enter into an interagency agreement for crosscutting responsibilities related to SMO functions listed above.

• The SMO will also be responsible for managing a provider network and providing care management services for individuals in PSH who qualify for 1915(i) behavioral health services.
1915(i) Service Arrangements

- The SMO will manage 1915(i) and (b) services; they have a combined risk and management only contract and can make alternative payment arrangements for the services.
- However they must certify any willing provider who meets qualifications for specific 1915(i) services.
- They will contract for medically necessary services that are covered by Medicaid or CDBG (for persons in PSH not yet on Medicaid but who qualify for PSH).
- The Office of Behavioral Health will certify providers to deliver PSH services across all disability groups.
- DHH will establish new training and competency requirements required for certification.
1915(i) Service Arrangements

- **CPST** and **ACT** are the two services most PSH recipients will be eligible to receive.

- These services are delivered in vivo.

- The SMO will assure there are a sufficient number of qualified CPST and ACT providers available to take PSH referrals in each of the state’s regions.

- The SMO will provide “care management” to help providers and service recipients navigate through the services and housing system and assure support is available during critical transition periods.

- This may include increasing the amount and type of services needed so the service recipient can remain stably housed.
CPST (Community Psychiatric Support Treatment):

- Assist the individual and family members or other collaterals to identify strategies or treatment options associated with the individual’s mental illness, with the goal of minimizing the negative effects of mental illness symptoms or emotional disturbances or associated environmental stressors which interfere with the individual’s daily living, financial management, housing, academic and/or employment progress, personal recovery or resilience, family and/or interpersonal relationships and community integration.

- Individual supportive counseling, solution-focused interventions, emotional and behavioral management and problem behavior analysis with the individual, with the goal of assisting the individual with developing and implementing social, interpersonal, self-care, daily living and independent living skills to restore stability, to support functional gains and to adapt to community living.
New 1915(i) Services

CPST (Community Psychiatric Support Treatment):

- Participation in, and utilization of, strengths-based planning and treatments, which include assisting the individual and family members or other collaterals with identifying strengths and needs, resources, natural supports and developing goals and objectives to utilize personal strengths, resources and natural supports to address functional deficits associated with their mental illness.

- Assist the individual with effectively responding to or avoiding identified precursors or triggers that would risk their remaining in a natural community location, including assisting the individual and family members or other collaterals with identifying a potential psychiatric or personal crisis, developing a crisis management plan and/or, as appropriate, seeking other supports to restore stability and functioning.
New 1915(i) Services

CPST (Community Psychiatric Support Treatment):

• Restoration, rehabilitation and support to develop skills to locate, rent and keep a home, landlord/tenant negotiations, selecting a roommate and renter’s rights and responsibilities.

• Assist the individual to develop daily living skills specific to managing their own home, including managing their money, medications and using community resources and other self care requirements.
New 1915(i) Services

Assertive Community Treatment (ACT):
The ACT program meets all the fidelity requirements for ACT programs. Services must be provided by an interdisciplinary team that provides service coordination; crisis assessment and intervention; symptom assessment and management; individual counseling and psychotherapy; medication prescription, administration, monitoring and documentation; substance abuse treatment, work-related, activities of daily living, social, interpersonal relationship and leisure-time activity services.

Direct assistance is provided to assist individuals to obtain the basic necessities of daily life, ensure that individuals obtain supportive housing, as needed; and education, support, and consultation to individuals’ families and other major supports. It also includes the same requirements as CPST to assist an individual to develop skills to locate, rent and keep a home, landlord/tenant negotiations, selecting a roommate and renter’s rights and responsibilities.
Target Populations

• The *Road Home* plan originally defined a cross-disability PSH target population.
• DHH worked with state agency staff & PSH advocates to further define eligibility & a targeting policy that balanced the goals of addressing homelessness & unnecessary institutionalization.
• Eligible were extremely low-income households with disabilities determined by DHH to be ‘in need of PSH’.
• In addition to these threshold criteria, the following eligible groups receive a program preference:
  • Hurricane Katrina or Rita displacees
  • People who are homeless or at-risk of homelessness
  • People living unnecessarily in institutions or at-risk of institutionalization
• The state established a goal that at least one-third of all PSH units would be occupied by eligible homeless households.
Target Populations

• The state established a goal that at least one-third of all PSH units would be occupied by eligible homeless households.

• As part of the state’s sustainability plan, the eligibility requirements have been changed slightly to add: applicants must be eligible for a federal or state funded services program available to people with disabilities; all other requirements remain the same.

• These programs fall into four broad categories (health related, long term care, developmental disabilities and/or behavioral health).

• This does not mean persons must be enrolled and receiving services but they must be eligible for services.
### Population/Demographic Information

#### Household Size
- Average = 1.7 people
- Range = 1-10 people

#### Age
- Average = 46
- 62 & over = 8%

#### Race/Ethnicity
- Hispanic/Latino = 2%
- African American = 68%
- White = 27%
- Other = 5%

Based on first 2,400 qualifying households served
Total people: 3250, includes all household members

#### Singles vs. Families
- S+C = 94% singles, 6% families
- PBV = 43% singles, 57% families

#### Population Targeting
- Homeless/At Risk, 58%
- Institutionalized/At Risk, 10%

#### Program Exits
- 5% turnover, few evictions
## Disability Status

<table>
<thead>
<tr>
<th>Diagnosis*</th>
<th>N</th>
<th>Primary Diagnosis %</th>
<th>Single Diagnosis %</th>
</tr>
</thead>
<tbody>
<tr>
<td>DD</td>
<td>282</td>
<td>8.7%</td>
<td>.7%</td>
</tr>
<tr>
<td>MH</td>
<td>1,515</td>
<td>46.6%</td>
<td>5.1%</td>
</tr>
<tr>
<td>SA**</td>
<td>65</td>
<td>2%</td>
<td>.2%</td>
</tr>
<tr>
<td>Health Related***</td>
<td>981</td>
<td>30.2%</td>
<td>30.2%</td>
</tr>
<tr>
<td>None/Other****</td>
<td>407</td>
<td>12.5%</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>3,250</td>
<td>100%</td>
<td>36.2%</td>
</tr>
</tbody>
</table>
Case Examples

- Small Town: QS

- Urban: New Orleans:
  - SB
  - Mary

- Rural: JS
Contact Information

Christine Rhorer
DHH PSH Program Director
Cristine.Rhörer@LA.GOV
(225)-342-5885

Marti Knisley
Technical Assistance Collaborative
mknisley@tacinc.org
(202)-431-9775
www.tacinc.org
Home and Community Based Services Rent Subsidy Program
Purpose of Program

- Provide a monthly rental assistance payment to eligible adults and children receiving services under Medicaid 1915(c) waiver until such time that the recipient becomes eligible for any other local, state or federal rent subsidy
- Assists Medicaid waiver eligible clients to live in the community instead of an institution
Program Rules

- Iowa Chapter 265—24 HCBS Rent Subsidy Program
History

- Began in 1996
- Originally administered by the Department of Human Services (DHS)
- Budget until late 1990s was $70,000
History

- Budget was increased to $700,000 in response to State’s efforts to develop more community-based options
- Increase in budget was supported by nursing home lobby as owners looked to develop assisted living and senior housing
- Well-kept secret within DHS; very little utilization of program
History

- Iowa Finance Authority (IFA) is charged by Governor Thomas Vilsack to serve as the lead agency for the Housing for Persons with Disabilities State Action Plan.

- In an August 2003 survey of public housing authorities in Iowa it was found that a person with a disability would wait from 6 months to 2 years before a Section 8 voucher would become available.
Timeline for Transfer

- February 2004: IFA approaches DHS with an offer to administer HCBS rent subsidy program
- June 2004: An interagency agreement is signed between DHS and IFA
- July 2004: IFA develops IT program to automate application processing
- August 2004: Rent subsidy program transfer complete
Transfer to IFA

- Legislature makes it permanent; program and funding is transferred to IFA
- Funding remains at $700,000
- Program has gone to “wait list” 3 times, shutting off new applicants for 6 months or longer
- Rent assistance is paid monthly via electronic funds transfer to the Medicaid waiver recipient or their payee
Current Status

- 387 participants on May 1, 2012
- 46 people on average added each month
- 41 people on average removed each month
- Projected net growth of 5 Medicaid waiver recipients each month
- Average rent subsidy: $161 per month
Eligibility Requirements: HCBS Recipient

- **Adult**: Participant in 1 of 6 waivers
- **Child**: Person under 18 receiving residential-based supported community living services under the Intellectual Disability waiver (cannot live with parent or guardian)
Eligibility Requirements: Demonstrated Need

- Responsible for paying more than 30% of income for rent
Eligibility Requirements: Demonstrated Need

- Not receiving and are ineligible for other rental assistance
  - “Ineligible” means the person has been placed on the waiting list, or the waiting list is closed
  - Once a person is offered another rent subsidy, they are “eligible” and HCBS subsidy ends (regardless of whether the person accepts the rent subsidy)
HUD Section 8 Program

- In consumer’s benefit to select an apartment initially that accepts Section 8 subsidy
- Eliminates the need to move once he/she becomes eligible for Section 8 voucher
- Reasonable accommodation: Can request extension in search time to find an apartment with needed accessibility features
Eligibility requirements: Risk of nursing facility placement

- Have insufficient funds to pay their community housing costs and that insufficient funds will cause them to enter a nursing facility or other institution.
- Access to this rent subsidy is required so that they may live in a community living arrangement.
Eligibility Requirements: Responsible for Rent

- Financially responsible for rent or housing costs
Proportionate Share of Rental Unit

- Equal to one bedroom of a multi-bedroom rental unit
- Exception can be made for qualified dependent relative, as defined by the State Supplemental Assistance (SSA) program
- **Actual rent**: $700

- $100\% \times \text{Fair Market Rent for a 2-bedroom rental unit in Polk County}: 
  \[100\% \times \$669 = \$669\]

- **Income**: $30\% \times \$650 = \$195$

- **Proportionate Share**: $\$669 \div 2 = \$334.50$

- **Subsidy estimate**: $\$334.50 - \$195 = \$139.50$

- actual rent $\div$ bedrooms = proportionate rent $- 30\%$ of monthly income $= \text{rent subsidy amount}$
Termination of subsidy

- Person does not meet eligibility criteria
- Person dies
- Completion of required documentation is not received (including change of information)
- No further funding available
For more information

- www.iowafinanceauthority.gov
- Go to “For Renters”
- Click on HCBS Rent Subsidy Program
Recommendations

- Meet with your State’s HCBS lead and learn about your State’s HCBS programs
- Learn how individuals are enrolled in your State’s HCBS programs
- Encourage your community to prioritize housing for people who are eligible for HCBS
- Become an HCBS provider or collaborate with HCBS providers
- Advocate for a targeted 1915(i) HCBS program to sustain and grow permanent supportive housing services.
Resources

Health Reform Resources
www.nhchc.org/policy-advocacy/reform/nhchc-health-reform-materials/

Permanent Supportive Housing Resources
www.nhchc.org/permanent-supportive-housing/

Request technical assistance, including a site visit for your organization.
www.nhchc.org/training-technical-assistance/technical-assistance-request-form/

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