

Strategies for Coordinating the Homelessness Prevention and Rapid Re-Housing Program (HPRP) with Medicaid and other Mainstream Health Care Benefit Programs

About this Tool

This guide describes how Homelessness Prevention and Rapid Re-Housing Program (HPRP) grantees and sub-grantees can coordinate HPRP services with Medicaid, the State Children's Health Insurance Program (SCHIP) and other mainstream programs that finance and deliver health care and behavioral health services.

PURPOSE OF THE GUIDE

HPRP funding provides a valuable new resource for communities to serve households that are homeless or at risk of homelessness, and it is vital that individuals and families receiving HPRP support are also able to link into existing mainstream resources. For many homeless or at-risk households, unresolved health crises or extraordinary health care expenses may lead to financial or housing crises. Therefore, access to health services through Medicaid, SCHIP or other sources of affordable health care may be an important strategy for preventing homelessness for those households. People who seek assistance from HPRP programs may have lost health insurance due to a loss of employment, or their connections to health care providers may have been disrupted because of a move related to a housing crisis. This guide includes an overview of Medicaid, SCHIP and HPRP, a description of strategies HPRP grantees and sub-grantees can use to coordinate with health care providers and public health insurance programs and models from other communities.

FUNDING: A SNAPSHOT OF ARRA FUNDING FOR HPRP AND MEDICAID

The HPRP program, administered by the U.S. Department of Housing and Urban Development, provides \$1.5 billion in American Recovery and Reinvestment Act (ARRA) resources for state and local governments to use to prevent individuals and families from becoming homeless and help those who are experiencing homelessness to be quickly re-housed and stabilized. Eligible grantees include metropolitan cities, urban counties, and states for distribution to local governments and private non-profit organizations. HPRP may be used by grantees to assist eligible households with financial assistance (including rental assistance, security and utility deposits, utility payments, moving cost assistance, and motel/hotel vouchers) and housing relocation and stabilization services (including case management, outreach and engagement, housing search and placement, legal services, and credit counseling).

The Medicaid program is a key mainstream resource already serving many of the same households targeted through HPRP. ARRA provides up to \$87 billion of increased funding for state Medicaid programs, to help them sustain Medicaid coverage during the current economic downturn. Each state will get a 6.2 percent increase in its Federal Medical Assistance Percentage (FMAP) payments, which is the federal match to state Medicaid programs, and states with relatively high unemployment rates may get additional increases based on quarterly unemployment statistics. Funding increases will be provided for FY 2009 through the first quarter of FY 2011. This money—which could total \$15 billion for the first

part of 2009 alone—was made available to states on February 25, 2009, and is expected to help states provide Medicaid benefits for millions of Americans.

MEDICAID AND SCHIP: AN OVERVIEW

Medicaid and SCHIP provide coverage for more than one in four children in the U.S., making these two programs important resources in providing care for low-income families as well as many individuals who may be at risk of homelessness. However, millions of low-income people who are potentially eligible for coverage remain uninsured. They are not enrolled for a variety of reasons, such as not knowing about the program, where to apply, or difficulties in completing the application process.

Medicaid is a federal/state partnership program that provides health benefits to Americans who meet both income and “categorical” eligibility requirements, including children, their parents, pregnant women, the elderly and people with disabilities. Over the course of the year, some 51 million people who would otherwise not have access to regular health care rely on Medicaid. Recent immigrants and undocumented immigrants are generally barred from federally-financed public coverage.

The federal [Centers for Medicare and Medicaid Services](#) (CMS) establish requirements for healthcare service delivery, quality, funding, and eligibility standards. If states meet these requirements, they are eligible to receive federal funding to cover a portion of each state's Medicaid costs. These matching dollars are referred to as Federal Medical Assistance Percentage (FMAP) payments. The requirements allow states substantial flexibility to address the needs of their own population within the constraints of state funding available for the non-federal share of program costs. For instance, although some basic benefits are “mandatory” and must be covered for all eligible Americans, states have considerable flexibility in determining which “optional” benefits they provide, who will be eligible and how much they will pay health care providers. As such, the Medicaid program varies from state to state, and states can brand the program with a unique state name such as "[Medi-Cal](#)" in California, "[MassHealth](#)" in Massachusetts, and "[TennCare](#)" in Tennessee. Specific information about Medicaid benefits available in each state can be found at http://medicaidbenefits.kff.org/state_main.jsp.

Medicaid also provides coverage for some behavioral health services (including mental health and/or substance abuse treatment services). These benefits can vary widely from state to state, and may be administered separately from other health services.

The State Children's Health Insurance Program (SCHIP) is also funded by an allotment of federal funding to each state, which is matched by state funding. SCHIP provides free or affordable health insurance for eligible children. States establish eligibility requirements and enrollment procedures, and nearly all states provide coverage for children in families with incomes below 200% of the federal poverty level (or higher). In recent years many states established outreach and streamlined enrollment procedures for SCHIP in order to reach more uninsured children, although some of these efforts have been reduced or stalled because of state budget crises. When Congress reauthorized the SCHIP program in 2009, states were given new options for “Express Lane Eligibility”, allowing state agencies to identify, enroll and recertify children when they provide information to establish eligibility for other benefits such as Head Start or Food Stamps. Most states charge premiums or enrollment fees for children's coverage, but costs are much more affordable than private insurance.

In most states low-income “childless adults” are not eligible for Medicaid unless they are elderly or eligible for SSI benefits because of a disability. For uninsured low-income adults who are not eligible for Medicaid, other mainstream resources, including Community Health Centers, Health Care for the Homeless programs, public hospitals and other “safety net” providers of health care and behavioral health services are the most likely sources of affordable health care services.

Community Health Centers (CHCs or community clinics) can serve patients who have Medicaid benefits, and they also offer affordable health care services for people who are uninsured. Fees are usually

determined on a sliding scale based on income. CHCs recently received additional federal funding through ARRA to help provide care for people who are uninsured. A portion of CHC funding is allocated to Health Care for the Homeless (HCH) programs, and many HCH programs are operated by or in partnership with CHCs that serve other low-income community residents.

STRATEGIES FOR COORDINATING HPRP WITH MEDICAID, SCHIP OR OTHER HEALTH CARE RESOURCES IN YOUR COMMUNITY

The HPRP program is a new resource for addressing the needs of people at-risk of homelessness or experiencing homelessness. The following are examples of approaches HPRP grantees and sub-grantees can use to ensure HPRP clients are linked to Medicaid or SCHIP benefits and other health services for which they may be eligible.

Coordinated Entry

- HPRP programs should be implemented in collaboration with existing multi-service centers or agencies where low-income people can have “one-stop” access to a range of services including enrollment in Medicaid or SCHIP and other benefits. For example in **Alameda County, California**, HPRP and other resources for homelessness prevention and housing support are available at regional Housing Resource Centers, where staff can help clients apply for benefits such as Medicaid or SCHIP. Multi-service centers are a particularly effective strategy for non-metropolitan areas with fewer community-based organizations. In these areas, the local department of social services may be the best location for clients to access or get referrals to HPRP resources. See Alameda County, California case study below.
- HPRP programs can also partner with health care providers to ensure that program participants are linked to affordable or Medicaid-reimbursed primary care services, SCHIP, care for chronic medical conditions, and recovery support services for mental illness or substance abuse problems. In **Chicago, Illinois**, school district homeless liaisons identify students who have become homeless or are facing a housing crisis and link families to prevention, re-housing assistance, and assistance in qualifying for Medicaid or SCHIP benefits if they aren’t already enrolled. See Chicago, Illinois case study below.
- Access to Medicaid, SCHIP and HPRP can be enhanced if states streamline applications for benefit enrollment. Recent changes in federal law allow states to establish “Express Lane Eligibility” to reach and enroll low-income and uninsured children who are eligible for Medicaid or SCHIP. When families provide information to establish eligibility for Head Start, Food Stamps or other benefits, the data can be used to conduct automatic enrollment (with consent by the parent). States that are implementing streamlined and automated enrollment systems for Medicaid and SCHIP may be able to utilize data collected from families for determining eligibility for HPRP services. Opportunities for coordination with planning for Express Lane Eligibility will be greatest where HPRP programs are being implemented by state agencies that also administer other benefits such as TANF or Supplemental Nutrition Assistance Program (SNAP) benefits (also known as Food Stamps). Other promising practices have demonstrated effectiveness in connecting persons to benefits. **Ohio** has established “benefit banks” where a person can be screened for and apply for a variety of benefits on-line with the assistance of trained staff in locations throughout the community. Beginning in 2010, the **State of Washington** will use mobile benefit vans to bring staff into underserved communities and help residents apply for benefits. Alternatives to applying for benefits at government offices, such as at food banks, at street fairs, at job sites, or at shelters, give potentially eligible clients easier access, thus improving rates of participation and supporting economic recovery at the household and community levels.

Staff Training

- Training may be needed for HPRP staff to become familiar with their state's eligibility requirements and enrollment procedures for Medicaid and SCHIP. Such training will improve their ability to identify potentially eligible program participants and help them enroll in benefits for which they may be eligible. In some states on-line applications are available, and documentation provided to establish HPRP eligibility may be submitted to establish eligibility for other benefits.
- Training on HPRP for staff of government social services programs and health care providers serving low-income people at risk of homelessness, (including Community Health Centers, public hospitals, mental health and substance abuse treatment programs), may be needed to help identify potentially eligible program participants and make appropriate referrals. These staff should have a good understanding of HPRP resources, eligibility criteria, access locations, and referral procedures. If staff is informed about HPRP resources, they are more likely to identify clients with housing crises and make timely referrals for prevention or rapid re-housing services.
- HPRP grantees should encourage funded providers to participate in SOAR (Social Security: Outreach, Access and Recovery assistance) trainings. These programs have demonstrated great success in helping to increase access to Social Security or SSI benefits, which may trigger eligibility for Medicaid, as well as in facilitating access to housing, and other support services for those experiencing homelessness. HPRP funds present an opportunity for organizations and/or communities to fund case workers to implement the lessons learned from SOAR. For information on SOAR and how to get SOAR started in your community through a ten step strategy with external links and examples follow this link: <http://www.prainc.com/soar/>.

Tailored Policies

- HPRP grantees and state Medicaid programs, health plans, and health care providers may tailor policies to meet the needs of families experiencing homelessness. This may include providing flexibility or additional assistance for families to meet requirements for establishing or maintaining eligibility for Medicaid benefits. Managed care programs or health care providers can also tailor policy to ensure timely access to appropriate care when households relocate because of a housing crisis.

Case Study: Coordinated Entry and Service Provision

In **Chicago, IL**, the Chicago Public Schools homeless school liaisons (funded by the Education for Homeless Children and Youth program of the McKinney-Vento Act) are identifying students experiencing homelessness and their families who need housing assistance. The school program works in partnership with Heartland Alliance, an organization that includes a Health Care for the Homeless program and behavioral health services funded by a combination of Medicaid and other federal, state and local resources, to deliver case management and mental health services. Services include support for families who need assistance to achieve housing stability and qualify for Medicaid benefits if they aren't already enrolled. (In this case housing assistance is provided from another funding stream, but the model is replicable for HPRP.) Heartland's Health Care for the Homeless program subcontracts with local Community Health Centers, so as families obtain housing the program helps to link them to a Community Health Center in their neighborhood.

Case Study: Coordinated Entry

In **Alameda County, California**, HPRP resources are available at regional Housing Resource Centers. In several parts of the county these housing resource centers are located in established multi-service centers or agencies where low-income community residents can have "one-stop" access to a broad range of services. HPRP case managers are familiar with the array of services available on-site or in the community and can help broker access to the clinic or other services and benefits, including Medicaid. The HPRP program is also working with Community Health Centers on "raising their housing consciousness" so health care providers serving low-income residents throughout the county will ask about housing crises and make referrals to the HPRP program when needed. The HPRP program is using an assessment that will identify and link participants to services needed to achieve stability, including mental health and other health services. Households needing more intensive support, such as permanent supportive housing, will be linked to resources available through the Continuum of Care and/or the county's Mental Health Services Act housing programs.