

Bridging the Health and Housing Gap

*Transitioning Medicaid Recipients from Institutions to the Community
in the Context of Housing Shortages and Affordability*



ACAP
Association for Community
Affiliated Plans



Executive Summary

The United States is on the cusp of a dramatic demographic shift.

With baby boomers entering retirement, the American population aged 65 and older is expected to more than double from 46 million today to more than 98 million by 2060.¹ This unprecedented growth, coupled with the increasing number of people with disabilities and dementia, particularly amid a housing affordability crisis, will have profound public health and housing implications for the United States. Now more than ever, it is imperative that housing and health authorities come together to create policy recommendations that will improve the well-being of Americans on a holistic level.

The U.S. Department of Housing and Urban Development (HUD) and the U.S. Department of Health and Human Services (HHS) have operated in silos for decades. With mounting evidence suggesting that “social determinants of health”—the conditions in which people are born, grow, live, work, and age²— play a larger role in health outcomes than medical factors, the two agencies have recently begun working more closely together.³ But they have just scratched the surface of a daunting undertaking. In the absence of well-established collaborations, health plans, local health and housing agencies, and other organizations have taken it upon themselves to create innovative pilots to bridge the health and housing gap.

The 61 health plan members of the Association for Community Affiliated Plans (ACAP) are investing in innovations that directly address social determinants, even if they fall outside the traditional bounds of Medicaid health benefits. This paper focuses on neighborhood and built environment, one of the five areas of social determinants as outlined by Healthy People 2020.⁴ It explores the challenges faced by Medicaid recipients in institutions, who are unable to transition back to the community in the face of unaffordable housing. It provides an overview of federal and Medicaid laws that have changed the landscape of long-term services and supports, and gives a general background of housing policies impacting Medicaid recipients. Finally, it highlights the work of five ACAP-member Safety Net Health Plans to help transition institution-bound enrollees back into the community.

Introduction

There are more than 3,100 counties and county-like entities in the U.S. Not one has enough affordable housing for its low-income residents. Nationwide, just 28 available, affordable housing units exist for every 100 low-income households.⁵ The low supply of affordable housing stock has exacerbated the issue of homelessness nationwide, and has significant implications for health and housing policy.

This paper focuses on people who experience transitional homelessness for clinical reasons. This could be someone who is admitted to a hospital, a skilled nursing facility, or long-term care, subsequently loses their home, and therefore cannot be discharged. People who find themselves in this situation face an extra layer of complexity: housing agencies that could help find homes for these individuals typically do not classify them as “homeless.”⁶

People who face transitional homelessness for clinical reasons typically include seniors and people with disabilities. The two categories are not mutually exclusive. Many are enrolled Medicaid recipients, whereas others have Medicaid and Medicare at the same time. Such people are referred to as “dual eligibles,” or “duals.” Duals tend to be among the poorest and sickest beneficiaries covered by Medicare and Medicaid, and represent

a disproportionate amount of healthcare spending, largely due to their greater need for long-term services and supports (LTSS).⁷

Tectonic shifts in demographics in the U.S. portend a rapid rise in seniors and people who may be dually eligible. More than 79 million seniors will be living in America by 2035; the number of older adult households with a disability will top 31.2 million by then, and the number of older adults with dementia will reach 7.6 million.⁸

An estimated 70 percent of these older adults will need long-term care. While most such care can be delivered at home, some will require the services of skilled nursing facilities. Many older adults today are assisted by family caregivers for self-care tasks, however, it is widely believed that in the future there will not be enough family caregivers to take care of older adults. Over time, paid care will become even more necessary; without caregiver support, the only option for many will be long-term care facilities.⁹

Today, 1.4 million Americans reside in nursing homes. Two-thirds of these people receive Medicaid coverage.¹⁰ However, one study found that up to 1 in 5 of these seniors—up to 280,000 in all—could live in less-restrictive environments if they had affordable alternatives with wrap-around services (Appendix).¹¹

While this paper focuses on transitionally homeless individuals, we must note that chronic homelessness and episodic homelessness may overlap. Homelessness among seniors is expected to rise by a third by 2020 and to double by 2050.¹² The scarcity of alternative housing solutions raises the risk of institutions serving homeless older adults as a high-priced substitute for affordable housing. Even today, homeless seniors are often caught in an ‘institutional circuit’ cycling between living on the street or in a shelter and living in an institution. Since many homeless older adults have considerable health care needs and need support in activities of daily living, sometimes the only permanent shelter available to them is a nursing home—or worse, a psychiatric hospital or jail.¹³ Because Medicaid pays for nursing homes, many times these individuals are forced to stay there when they could be living in a community-integrated setting at far lower cost.¹⁴ While the federal government is taking steps to address this challenge, the need is greater than can be met—and the need is expected to continually grow.¹⁵

Other Medicaid beneficiaries faced with unaffordable and inaccessible housing options are non-elderly adults with physical, intellectual or developmental disabilities (I/DD). One study finds that more than 200,000 non-elderly people with disabilities reside in nursing homes.¹⁶ These individuals face a severe housing crisis; many live on Supplemental Security Income (SSI). The average SSI payment in 2014 was \$721, while the national average one-bedroom unit was \$780 and \$674 for a studio. While government housing subsidy programs exist, many, like the Section 8 program, are frequently underfunded and have long wait lists. The high cost of housing coupled with disabled individuals’ limited incomes leads many individuals to becoming chronically homeless.

Federal Policies and the Impact on Health Care

The American with Disabilities Act (ADA) is a key policy that has significantly impacted this issue. Title II of the ADA requires public entities to administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities. This provision is the central question in *Olmstead v. L.C.*, a Supreme Court case which significantly changed the landscape of community-based services. In 1999, the Supreme Court held that public entities must provide community-based services to individuals with disabilities when the services were appropriate, the individual was willing to be transitioned, and the individual

would have the necessary resources to be accommodated.¹⁷ While *Olmstead* did not change Medicaid law, it did have a significant impact on Medicaid, given that Medicaid is the major payer for long-term services and supports (LTSS), including home- and community-based services (HCBS).

Federal Health Policies

The traditional Medicaid program, however, has a structural bias towards institutional care, a covered Medicaid benefit, while most HCBS are provided as a state waiver option. But unlike Medicaid, enrollment in state waiver programs can be capped, and long waiting lists can result. In 2012, approximately half a million people in the U.S. were on HCBS waiver waiting lists. The average wait was estimated to be more than two years.¹⁸

Nevertheless, several Medicaid waivers have been very beneficial in helping transition individuals back to the community. By law, Medicaid is prohibited from covering rent, but under certain waivers states can cover housing-related services. For example, under Medicaid's 1915(c) Home and Community Based (HCBS) Waiver Program, housing transition and tenancy-sustaining services can be covered for people that meet institutional settings of care. These include help with searching for and securing housing, security deposits, establishment of utility accounts, and basic home furnishings.

Benefits under Section 1915 can be accessed through other waiver programs:

- Medicaid's 1915(b) waiver gives states the option to offer HCBS to individuals with disabilities, adults needing long term services and supports (LTSS) and individuals experiencing homelessness.¹⁹
- Under the 1915(i) waiver, states can offer HCBS to people with disabilities or behavioral health issues who need less than an institutional level of care.²⁰
- The 1915(k) waiver, also known as the Community First Choice, gives states the option to provide HCBS to people who are eligible for Medicaid and have incomes below 150 percent of the federal poverty level, but who do not meet the institutional level-of-care criteria. It also provides HCBS to individuals who meet the institutional level-of-care but whose income exceed 150 percent of the federal poverty level.²¹

Another waiver is 1905(a), which provides targeted case management (TCM) services under the Medicaid State Plan. This may be beneficial for individuals transitioning from institutions to the community and trying to maintain their community housing. TCM services are utilized to assist individuals in gaining access to needed medical, social, educational, and other services.²² Alternatively, Section 1115 of the Social Security Act gives HHS the authority to approve experimental, pilot, or demonstration projects designed by the state that will ultimately improve the triple aim, that is, to improve health outcomes, reduce costs and increase beneficiary satisfaction. States can therefore use section 1115 for housing-related services like those described above.²³ Another important program is the Balancing Incentive Program (BIP), created under the Affordable Care Act, which provides financial incentives to states to increase HCBS. Through BIP funding, states have been able to increase the number of waiver slots available, increasing beneficiaries' access to HCBS (Appendix).

Finally, a very significant grant, established in 2005, to help transition individuals from institutions to community based settings is the Money Follows the Person (MFP) Rebalancing grant, a four-billion-dollar grant that will expire in 2020.²⁴ MFP programs have hired or contracted with housing specialists and coordinators, as well as case managers to provide housing-related services similar to those described above.²⁵ In order for individuals to be eligible for MFP, the Medicaid beneficiary must reside in a qualifying institution for at least 90 days before the transition to a community setting takes place. For each beneficiary receiving HCBS, the state receives enhanced federal matching funds. Non-traditional services such as home-delivered meals, wheelchair ramps,

home modifications or even support for caregivers could all be provided under this program. As of May 2016, 44 states, including the District of Columbia, had operational MFP programs. According to the Kaiser Family Foundation, MFP states have collectively transitioned more than 52,000 Medicaid beneficiaries from institutions to a community home over the course of the last eight years.²⁶

In recognition of the 10th anniversary of *Olmstead*, President Obama designated 2009 as the “Year of Community Living”, directing \$140 million toward independent living centers as well as a new coordination between the Departments of Health and Human Services and Housing and Urban Development. This initiative aimed to “support and promote opportunities for community integration, including increased access to community-based housing through federal housing subsidies.”²⁷ Several programs were created because of this initiative to include the Non-Elderly Disabled Housing Choice Voucher program and the revised Section 811 Project Rental Assistance (discussed below). Collaborations like these will ultimately look at the health of individuals from a holistic perspective, taking into consideration how lack of affordable housing or substandard housing conditions and health are inextricably linked.

Federal Housing Policies

To better serve the needs of these transitionally homeless Medicaid recipients, we also need to understand the various housing subsidies and assistance programs that are available to them. The Housing Choice Voucher Program (also known as Section 8) “is one of the most successful federal housing programs funded by HUD.”²⁸ People and families with incomes at or below 50 percent of area median income receive a voucher, to use toward the housing of their choice, provided it meets program requirements. At least 75 percent of vouchers go to households with incomes below 30 percent of the area median income. The subsidies are long-term and are considered permanent housing. Eligibility requirements for Section 8 vary by state, and are not necessarily aligned with Medicaid eligibility requirements. For example, someone who makes \$30,000 a year in Rockland County, New York would qualify for Section 8 housing, but not for Medicaid (Appendix).²⁹

A separate program, Section 202, provides funding to support multifamily housing for the very low-income elderly.³⁰ Section 202 is the only federal program that specifically addresses the need of affordable housing for the elderly. In 2004, the federal government allocated \$20 million to create the Section 202 Demonstration Program. This partnership between HUD’s Office of Multifamily Housing Programs, the Office of Policy Development and Research with Congress and HHS examines the Medicare and Medicaid expenditures of 12 cities to evaluate the potential of HUD programs to reduce health care use and expenditures among the low-income elderly.³¹ A limitation of the program, however, is that HUD can only provide this type of housing to one in three seniors who qualify.

Another housing program, the Section 811 Supportive Housing Program, provides funding for disabled, low-income households. Section 811 provides interest-free capital advances and operating subsidies to non-profit developers who build housing for individuals with disabilities.³² More than two-thirds of Section 811 residents who have come from nursing homes, hospitals or other specialized residences have developmental disabilities and chronic mental illness. Many of these people are at risk of homelessness or have experienced chronic homelessness. One important feature of Section 811 is the Frank Melville Supportive Housing Investment Act of 2010. Under this Act, new Project Rental Assistance funding was provided to State Housing Agencies to create integrated supportive housing, on the condition that they work with the state’s Medicaid agencies--an encouraging step towards integrating the two.³³

Case Studies: ACAP Plans' Innovations

In the absence of strong federal health and housing partnerships, health plans have created innovative pilots to bridge the divide and provide solutions to individuals experiencing transitional homelessness. The five ACAP health plans interviewed below have made, or are in the process of making, great strides towards building partnerships with housing and other organizations to best serve their members.

Health Plan of San Mateo

Health Plan of San Mateo (HPSM), a local public health plan, provides health care benefits to about 150,000 underserved residents of San Mateo County, located just south of San Francisco. They provide coverage through five programs: Medi-Cal, Care Advantage Cal MediConnect (a duals demonstration program), Healthy Kids, San Mateo County Access and Care for Everyone (ACE)/Health Worx.

In 2014, HPSM worked with the Institute on Aging (IOA) and Brilliant Corners (BC) to launch the Community Care Settings Pilot (CCSP). The goal of the pilot is to transition people living in nursing homes back to the community. IOA provides intensive transitional case management, while BC, a housing services agency, delivers housing services and support housing retention. HPSM also partners with other key housing organizations, including affordable senior housing developers, county agencies (e.g., Aging and Adult services and Behavioral Health and Recovery Services), hospital and nursing facility discharge planners and social workers, as well as a network of assisted living facilities.³⁴

The pilot taps into different housing sources tailored to a member's circumstances and needs. It could range from assisted living to affordable housing to helping a member stay in their own home.

The target population includes enrollees who:

- Live in long-term care settings, but could transition to lower levels of care;
- Are in an acute, rehabilitation or skilled nursing facility and need LTSS owing to medical issues that affect their ability to live independently, such as a stroke or fall; or
- Live in the community, but are at risk of institutionalization without additional supports.³⁵

Staff at skilled nursing facilities (SNF), HPSM's case managers, hospital discharge planners, county agency case managers, supportive housing managers, social service programs or primary care providers identify potential individuals and complete an intake form to see if they will be eligible for the program.³⁶ If the candidate is deemed to be appropriate for the program, an IOA case manager conducts an in-person interview. The interview forms the basis of a case prepared by the case manager that is presented to the Pilot Core Group, an assembly of representatives from IOA, HPSM, BC and San Mateo County's behavioral health and aging and adult service agencies. This group meets every two weeks to discuss cases, coordinate placements, and make appropriate modifications to an individual's care plan.

It typically takes three to six months to transition a program participant from a skilled nursing facility or long-term care facility back to the community. The IOA case manager leads the transition and meets not only with the member, but with all people involved in the member's care, to include: the member's family, physicians and social workers. Some of the challenges when transitioning individuals to the community include assuring the individual has appropriate services, such as in-home supportive services (IHSS)(Appendix), durable medical equipment and medications. Some programs that will serve the client must be coordinated prior to discharge

while others can only be arranged post-discharge, so case managers arrange services to ensure a safe discharge, often purchasing services as a bridge to connection to benefits only available in the community. IOA also connects individuals with long-term services and supports such as Meals on Wheels, paratransit services, and California's Community Based Adult Services (Appendix).

HPSM regularly measures the quality and value of the program's services using internal data and other information collected by partners. A recent quarterly review, through December 2016, indicated a reduction in costs of 46 percent for the six months after discharge compared with the six months prior to discharge. Satisfaction surveys have indicated high levels of satisfaction with the services provided and the impact on their lives.

As of October 2017, CCSP has transitioned 192 people to the community. To date, just seven have returned to institutional care. The impact of the program on individual members' lives is significant, and without such supports over the long term most individuals would return to a long-term care setting, which would lead to cost growth and a decrease in quality of life for members. It would also exacerbate issues around capacity, as long-term care beds are in especially short supply in the Bay Area.

HPSM leverages numerous different funding and resources to finance the Community Care Settings Pilot. These include benefits under California's CalMediConnect Medicare Medicaid demonstration, Home and Community Based Waivers, the Money Follows the Person demonstration, county partnerships and services, and the health plan's strategic investment fund.³⁷ Some of these resources have limitations, though when woven together they account for the majority of the cost of the program. That said, there are concerns regarding sustainability, particularly for ongoing services and supports currently paid for through the Care Plan Optional (Appendix) spending that is part of CalMediConnect, which is not built into the rates.

Another major challenge for CCSP is the paucity of available affordable housing and assisted living facilities in the Bay Area. CCSP has demonstrated that enabling vulnerable beneficiaries to age in place, particularly those with mobility challenges, behavioral health conditions, or dementia is possible when benefits are flexibly tailored and coordinated across agencies, including non-profit affordable housing operators like Mid-Pen and HumanGood and local assisted living facilities. Finally, information sharing among partners is another challenge that can impact programs like CCSP, where timely and comprehensive information on members is critical both to care planning and ongoing management of cases. Efforts in this area have improved coordination but from both a regulatory and operational perspective remain challenging and can impact care.

CareSource

CareSource is a not-for-profit managed care plan based in Dayton, Ohio, serving approximately two million Medicaid, Medicare Advantage, CareSource MyCare Ohio (CareSource's Dual Demonstration) and Exchange members in five states.

In its home state of Ohio, CareSource has developed several programs to help transition members in institutions back to the community through funding from 1915(c) and 1915(i) waivers, as well as their own internal budget. "Care4U", for example, offers members a full continuum of services through the support of community-based regional-care coordination teams, focused on meeting individuals' specific needs. The team is made up of Medical Directors, Care Coordinators, RN Care Managers, Community Health Workers and Facility Care Liaisons. The team engages the member through face-to-face and in-home meetings, phone calls, emails and mailings.³⁸ CareSource has also partnered with local area agencies on aging to help individuals obtain home and community-based care. An important element of their program is linking members with care coordinators as

soon as nursing home placement occurs. This way the care coordinators ensure a care plan is created. This coordination of care from the beginning of nursing home placements helps ease the transition to the community, should the member be able and willing to transition back.

CareSource is currently in the midst of developing an innovative permanent supportive housing model, targeting frail, older adults residing in nursing homes or long-term care rehabilitation centers, who could be living in lower level of care settings, as well as individuals living in sub-standard housing who are isolated from social services. The pilot is a collaboration with Brown, Gibbons, Lang and Company Investment Bankers (collectively referred to a “Gibbons”), that bring a wealth of experience in senior focused communities. Gibbons’ organization owns the Indian Hills Senior Living housing complex located in Euclid, Ohio; a complex that has easy access to bus transportation, as well as on-site, or near-by primary care and social services. The complex has sufficient vacancies that will enable CareSource to target 30-40 members during the first year of the pilot. The pilot will incorporate telehealth services in the housing units. In addition, CareSource will partner with Gibbons to have medical and social service tenants fill open retail space in close proximity to the housing site. CareSource will also provide ready access to home care services and is also exploring the possibility of having nurse practitioners do home visits. There will be on-site care management and a 24-hour on-call nurse. CareSource will also provide free internet and cell phone services. Finally, the members will be placed in close proximity to one another in an attempt to create a sense of community and encourage social connectivity.

The program would be financed through CareSource’s administrative budget, with the assumption that there will be a return on investment. The program will be evaluated on the following criteria:

- Pre- and post-pilot Medicaid spending for the selected residents;
- Rebalancing ratio for the region, pre- and one year post;
- Member satisfaction and quality-of-life survey results pre- and post-pilot;
- Total cost of care as compared against a similarly-situated control population; and
- ED visit rate and readmissions compared to MyCare regional population.

CareSource also taps into Ohio state’s Home Care Waiver program, Home Health Services, Helping Ohians Move, as well as the Recovery Requires a Community program (Appendix). Early research on the collaboration between Home Health Services and CareSource demonstrates that members with behavioral health diagnoses tend to have better experiences when combined with these services. CareSource is preliminarily reporting a one-third reduction in nursing home stays.

While CareSource has developed and continues to develop robust programs to address the needs of individuals who want to transition to the community, the availability of permanent supportive housing and Section 8 vouchers continue to remain the largest barrier. With the demand of Home Health also being greater than the supply, CareSource stepped in and created their own Home Health program in their geography. CareSource is developing innovative solutions to bridge the housing and health gap. But they continue to face challenges with fragmented data systems that prevents them from seeing a holistic view of the members and effectively serving their whole-person needs.

Inland Empire Health Plan

Inland Empire Health Plan (IEHP) is a nonprofit Medicaid and Medicare Managed Care Health Plan that serves more than 1.2 million members in the California counties of Riverside and San Bernardino, collectively known as the Inland Empire. Among IEHP’s Medicaid members, more than 3,500 are in custodial care, an estimated 500 of whom may be appropriate, willing candidates to transition back to the community.

IEHP's Governing Board recently approved a multi-year initiative to address housing issues in the Inland Empire. The initiative will first create a transition program to provide housing assistance for people who are willing and able to transition out of institutions and back into the community. IEHP has partnered with the Institute on Aging and Brilliant Corners, two agencies with experience in similar health plan-affiliated programs and population. The program is still in development.

Evaluation criteria for this initiative will include:

- Impact on costs;
- The program's efficiency, measured by the length of time it takes for members to successfully transition to the community;
- Member retention in the community;
- Member health and quality of life;
- Member satisfaction; and
- Provider satisfaction.

Funding for the programs comes from IEHP's administrative budget. Program goals also include identification of additional services such as In-Home Supportive Services (IHSS) and funding for members such as Social Security payments.

While this comprehensive housing initiative program is new, it builds on IEHP's previous initiatives to transition members from care institutions back to the community. With the help of IEHP's Utilization Management transition of care team, the Managed Long-Term Services and Supports (MLTSS) case managers and community partners, IEHP successfully transitioned 570 members to the community between January 2016 and September 2017. IEHP has partnered with a variety of case coordination and case management organizations to make these transitions possible. These teams – which include clinicians and case managers – have allowed members to succeed in community-placement settings. These programs have included members transitioning to a home, assisted living in a residential care facility or even to an apartment with assistance from the HUD Housing Choice Voucher program.

IEHP also provides a variety of programs, such as health education, disability programs, behavioral health services and community-based adult services, all of which contribute to the individual's ability to live in the community.³⁹

The most notable challenge in transitioning individuals to the community, as cited by all other plans interviewed, is the persistent difficulty in finding available affordable housing. IEHP added that rents in its service area continue to increase, while vacancy rates remain low.

Additionally, when a member is transitioned into a residential care or assisted living facility, this level of care is not an allowable expense under current Medi-Cal rate development categories even though it reduces overall cost of care for the member. The plan is not reimbursed by the State for this expense.

IEHP staff add that many members are unaware of the various programs available to them, such as IHSS, which is why having a case manager in a managed care model is very important to the individuals and is a crucial step to transitioning back to the community: they can connect members with resources they might not have known about otherwise.

Housing programs and service delivery are fragmented, siloed and complex propositions. Limited resources force local HUD-funded Continuums of Care to prioritize the populations served. The complexity makes it difficult for a health plan to know whether a member qualifies for a housing program and whether the capacity is there to provide services in the first place. IOA and BC provide the expertise to navigate these housing programs.

Finally, the siloed nature of program data presents another persistent challenge for IEHP and other health plans. The housing authorities, health plans, and community based organizations all house different data sets. It is not until they are able to share and combine data, that they will see the member from a holistic perspective and be able to better serve them and their needs.

Cardinal Innovations Healthcare

Cardinal Innovations Healthcare of North Carolina is the largest specialty health plan in the U.S. It serves more than 875,000 Medicaid members with complex needs. Of these members, approximately 1,600 live in Adult Care Homes—residences for aged or disabled adults who may need 24-hour supervision and help with activities of daily living.

North Carolina is unique compared with other states discussed in this paper: in 2012, the State entered a settlement agreement with the U.S. Department of Justice as a result of the state's violation of *Olmstead*. The purpose of the settlement was to assure that individuals with Severe Mental Illness (SMI) or Severe Persistent Mental Illness (SPMI) have the option to live in their communities, or in the least-restrictive setting of their choice. The North Carolina Department of Health and Human Services is using the Transition to Community Living Initiative to implement the settlement.⁴⁰

Under this agreement, by the year 2020 the state will provide community-based supportive housing to 3,000 individuals who are unnecessarily segregated in, or at risk of being segregated in adult care homes. These 3,000 housing slots include housing vouchers, rental subsidies, tenancy support or transition support that will help these people transition to affordable housing.⁴¹ As part of the settlement, the state provides Cardinal \$2,000 for each person that the plan helps transition to the community. In certain circumstances, Cardinal Innovations may also invest an additional \$3,000 per member to support the transition. These expenses can include moving assistance, furniture, first month's rent, application fees, and other costs associated with getting a member set up in independent housing.

Individuals can also tap into state programs, such as the State-County Special Assistance and Targeted Unit Transition Program for further assistance(Appendix). The North Carolina Department of Health and Human Services has created target numbers for each health plan or participating entity to transition. As of October 2017, Cardinal Innovations has transitioned 469 individuals.

The Transition to Community Living Department at Cardinal is made up of four teams:

- The **In-Reach Team** consists of certified peer support specialists that go to adult day care homes and meet with prospective members that they can safely transition back to the community. If the member agrees to the transition, then they refer them to the Transition Team. If the member does not agree to the transition, then they follow up with the member every 90 days, should the member change their mind (unless the member asks to be removed from the program, at which point they remove them from the call list).

- The **Transition Team** coordinates the clinical, social and housing needs of the member and connects them to mental health providers.
- The **Housing and Employment Specialists Team** specializes in housing options available in the community and ensures that individuals are placed in the appropriate housing. This team partners with Social Serve, a non-profit that helps individuals find housing. They help run background checks for the members and confirm that landlords will accept the member. This team also coordinates with the Tenant Based Rental Assistance Program as well as North Carolina Housing Finance Agency's Community Living Voucher (Appendix).
- Finally, the **Post-Transition Team** helps move people to their new setting and checks in on them three, six and twelve months post-transition. State programs that further assist individuals to live independently in the community include the Assertive Community Treatment Team, as well as Individual Placement Support-Supported Employment (IPS-SE)(Appendix).

An important challenge highlighted by Cardinal Innovations is that behavioral health and medical providers don't understand the housing arena, and vice versa. There is a disconnect between the medical and social housing programs, and until these two entities start having dialogues, it will continue to remain a challenge to bridge the two.

Cardinal Innovations teams also work hard to reduce the stigma associated with SMI and SPMI. Many landlords are hesitant to lease to individuals with mental illnesses, fearing a higher risk of damage to their property. And when a housing complex is sold to another party, especially large real-estate investment organizations, evictions arising from the stigma of SMI and SPMI can result.

Another challenge Cardinal has found is getting people employment opportunities. When Cardinal first started transitioning people they thought they would focus on transitioning individuals first, and employment opportunities second. Cardinal has learned that doing the two simultaneously enhances members' independence and are working towards moving employment placement earlier in the transition cycle, where possible.

The complex comorbidities that come with SMI and SPMI pose a different set of challenges for Cardinal when transitioning individuals to the community. Providing medical support for these individuals is a complex task, often requiring creativity on the part of the health plan. Further, people who live with substance use disorders that transition to the community have easier access to substances than they do in supervised setting such as adult care homes, and hence may need greater support.

Ensuring members have social connections in the community is another key challenge when transitioning care settings. Even if they have housing support, and medical support, a key component to thriving in the community is having social connectivity, and that's something that also needs to be addressed when moving people from institutions back to the community.

L.A. Care Health Plan

L.A. Care is the nation's largest publicly-operated health plan. The plan serves more than two million direct and plan partner members throughout Los Angeles County. They provide coverage through five programs: Medi-Cal, L.A. Care Covered (L.A. Care's Marketplace product), L.A. Care Covered Direct, Cal MediConnect (duals demonstration) and a PASC-SEIU plan for home care workers. This paper focuses on L.A. Care's direct Medi-Cal and Cal MediConnect (CMC) members that use long-term care and supports.

L.A. Care utilizes state programs to help transition institutionalized members to the community. These include the Assisted Living Waiver, the California Community Transition (CCT) program, and the Multipurpose Senior Support Program (MSSP) (Appendix). The Assisted Living Waiver and MSSP are waitlisted, which creates more challenges for the plan.

Understanding the key role caregivers play in supporting members live in the community, L.A. Care has invested in caregivers. L.A. Care developed an internal Caregiver Workgroup to improve the health of Medi-Cal and CMC members through enhanced caregiver training and support. The workgroup is led by L.A. Care's Health Services Department, with support from Medi-Cal Product, Communications, the Family Resource Center, Behavioral Health, Social Services, and Managed Long-Term Services and Supports (MLTSS), among other stakeholders. The first phase of the workgroup is focusing on caregivers of members with Alzheimer's Disease and dementia. Several L.A. Care staff members in the Social Services Department have been trained as Dementia Care Specialists and actively use the AD8 cognitive assessment and the Benjamin Rose Institute Caregiver Strain Instrument.

L.A. Care has also collaborated with the Alzheimer's Association of Greater Los Angeles (ALZ) to create a training program for L.A. Care's care management staff. These case managers will then have the necessary tools to help caregivers, who in turn help L.A. Care's members. In addition, L.A. Care will work with ALZ to create a referral process to USC's Leonard Davis School of Gerontology Los Angeles Caregiver Resource Center (LACRC), either from L.A. Care's care management department or from ALZ.

Furthermore, Health Services is working on enhancing the cognitive assessment in Clinical Care Advance—L.A. Care's technological application used by Health Services and other departments to monitor members' care—to better screen for dementia and Alzheimer's and to help coach caregivers to reduce caregiver burnout.

Moreover, the workgroup will begin examining data from members' Health Risk Assessments (HRA) to analyze members' gaps in care, particularly as it relates to caregiver support. Questions on the HRA related to caregiver support include activities of daily living, transportation issues, help with paying bills and help getting food.

Finally, L.A. Care has recently contracted with The California Long Term Care Education Center (CLTCEC) to train In-Home Supportive Services (IHSS) Workers (Appendix), who provide support to L.A. Care's Medi-Cal and CMC members. CLTCEC is the largest trainer of IHSS workers in California, training more than 2,500 workers per year.⁴² CLTCEC has begun a 10 week in-person training course to IHSS workers on topics ranging from home safety and competency checks to infection control precautions, nutrition and diet. The purpose is to provide IHSS caregivers with new skills and heightened awareness about health and well-being affecting the L.A. Care members whom they support. The objective is to reduce avoidable ER visits and improve health outcomes and care coordination. As one study states, "The more instruction and support caregivers receive to perform essential job tasks, the better they can perform and the better the quality metrics will be."⁴³ Since caregivers play a critical role in helping members stay at home, it follows that investment in the individuals helping to achieve this goal will see substantial returns.

L.A. Care faces several challenges with transitioning Medi-Cal and CMC members to the community. As with other plans, housing shortages and affordability is a primary challenge. Another challenge is program access: the Assisted Living Waiver and MSSPs have waiting lists.

Another layer of complexity to helping transition individuals to the community is the magnitude of member assessments. There are multiple assessments within L.A. Care, and several additional assessments delivered through the agencies serving these members. Having numerous assessments is not only burdensome for the member, but contributes to a counterproductive fragmentation of care. These assessments are housed in a variety of data sources; not all are accessible to the health plan. These issues underscore the importance of creating partnerships and breaking the housing and health silos.

Conclusion

In the context of our rapidly changing demographics in the U.S., transitional homelessness is a vital issue. Addressing it requires an effort that stretches beyond the traditional boundaries of health care—it requires a social, housing and whole-person care perspective. While there has been preliminary progress towards bridging the gap between the housing and health care authorities, there is much more work to be done.

It has been 18 years since the *Olmstead* decision, and eight years since President Obama declared 2009 as the “Year of Community Living” and the Community Living Initiative was launched. Yet we continue to see individuals housed in institutions who would prefer to live in the community if they had the means and resources to do so.

The challenges highlighted by the five ACAP plans herein are not unique and need to be addressed from a public policy perspective. Most notably, the lack of affordable and accessible housing remains the biggest challenge to transitioning individuals out of institutions. The policy framework that has traditionally siloed housing and health care is an ongoing challenge: the gap between the two is often where many transitionally-homeless seniors find themselves. One major step in bridging the gap between the two arenas is further education and cross-training. Another gap to bridge surrounds data: it is imperative to find ways that HHS and HUD could share key data sets in a way that maintains patient privacy protections.

Other challenges that resonated across all plans is assuring that these individuals who are placed in housing continue to receive support after their transition. Finally, we must not only invest in solutions to getting people out of institutions, but diverting them from the institutions in the first place. While caregiver initiatives have been created at a federal level, much more attention is needed to be directed to caregivers, particularly in providing support, education and training.

The elderly population, individuals with disabilities and individuals experiencing homelessness are growing at an unprecedented rate. While Safety Net Health Plans and other organizations and governmental agencies throughout the country are developing solutions and investing resources, they are doing so in the absence of a robust, national solution to address transitional homelessness for clinical reasons or the broader homelessness crisis. When all stakeholders come together to create holistic, national policies that bridge the health and housing gap, we will see real progress towards improving the lives of Americans today and tomorrow.

Appendix

Balancing Incentive Program

The Balancing Incentive Program (BIP) increases the Federal Matching Assistance Percentage (FMAP) to states that create structural reforms to divert individuals from nursing home care to non-institutional LTSS. States that spend 25 to 50 percent of non-institutionally based LTSS are eligible for a two percent enhanced FMAP, while states that spent less than 25 percent on non-institutionally based LTSS are eligible for a five percent enhanced FMAP.⁴⁴ As of May 2015, eighteen states were participating in BIP. States have reported that BIP is helping them rebalance LTSS in favor of HCBS. HCBS has grown in eighteen states, with fourteen states having grown by 25 percent or more between 2009 and 2014.⁴⁵

California's Assisted Living Waiver

The Assisted Living Waiver's goal is to help transition Medi-Cal eligible seniors and persons with disabilities from a nursing facility to a community home-like setting, such as a Residential Care Facility (RCF), an Adult Residential Care Facility (ARF), or public subsidized housing. The waiver can also be used as a diversion program for beneficiaries residing in the community who are at risk of being institutionalized. In order for individuals to be eligible to participate in the waiver they must be 21 or older, have full-scope Medi-Cal with zero share of cost, have care needs equal to those of Medi-Cal funded residents living and receiving care in Nursing Facilities, be willing to live in an assisted living setting as an alternative to a Nursing Facility, be able to reside safely in an assisted living facility or public subsidized housing and willing to live in an assisted living setting located in the designed counties.⁴⁶ Services available under the assisted living waiver include: Assistance with activities of daily living such as bathing, grooming or toileting; Assistance with the instrumental activities of daily living such as transportation and medication administration; Health related services including skilled nursing if necessary; Social and recreational activities; Prepared meals; Housekeeping and laundry; Nursing home transition care.⁴⁷ The Assisted Living Waiver is at full capacity of 3,700 participants and in May of 2017 a waitlist program began.

California's Community Based Adult Services (CBAS)

California's Community Based Adult Services is a Medi-Cal Managed Care benefit that offers the elderly or people with disabilities a wide array of services to help individuals to continue live in the community and avoid institutionalization. Services offered by CBAS include professional nursing services, physical, occupational and speech therapies, mental health services, transportation, meals and nutrition counseling.⁴⁸

California's Community Transition (CCT) Program

California Community Transition (CCT) Program is California's Money Follows the Person Program (MFP). In order to be eligible for CCT, individuals need to have been Medi-Cal eligible for at least one day, have continuously been in a nursing home for at least 90 days (not counting any days covered by Medicare), and continue to require the same level of care in a health care facility. The CCT program is open to persons of all ages, however it specifically targets elders, persons with development disabilities, physical disabilities and mental illness. The CCT program helps individuals transition to the community, specifically to apartments, houses, publicly subsidized housing, assisted living facility, or small group homes. CCT Services include: pre and post-transition coordination, home set-up, including rental assistance, and utility deposits, habilitation, family and informal caregiver training, personal care services (pre-IHSS), home and vehicle modification, assistive devices and transitional case management. CCT works through the partnerships of different organizations coming together and emphasize whole person care. These include the Department of Health Care Services (DHCS), Home and Community Based Services, Managed Care Organizations, Housing and Skilled Nursing Facilities.⁴⁹

California's In-Home Supportive Services (IHSS) Workers

IHSS is a federal, state, and locally funded program that provides personal and domestic care services to beneficiaries who are 65 years of age or older, blind or disabled.⁵⁰

California's Multipurpose Senior Services Support Program (MSSP)

The Multipurpose Senior Services Support (MSSP) program is a 1915 (c) Home and Community Based Waiver that services Medi-Cal eligible individuals who are 65 years or older and disabled as an alternative to nursing facility placement. The cost of MSSP to Medi-Cal is \$359 a month as opposed to an average of \$3,200 for a nursing home.⁵¹ Services that MSSPs provide include: Adult Day Care/Support Center, housing assistance, which includes physical adaptations and assistive devices, emergency assistance in situations that require relocation, temporary lodging expenses in specific situations and help with

restoring utility services, chore and personal care assistance, protective supervision, care management, respite, transportation, meal services, social services, communications services.⁵²

California’s Care Plan Options

Care Plan Options are optional services the plan may provide that are above and beyond LTSS and HCBS in order to enhance the member’s care. The goal of Care Plan Options is to help allow members stay in their home and prevent institutionalization. These optional services are not part of Medi-Cal covered benefits. These can include: Supplemental personal care and shore services (above authorized IHSS); Supplemental protective supervision; In home skilled nursing care and therapies services for chronic conditions; Respite care (in home or out-of-home) not to supplant authorized IHSS hours; Nutritional supplements and home delivered meals; Care in licensed residential care facilities; Home maintenance as well as minor home or environmental adaption; Medical equipment operating expenses and Personal Emergency Response System (PERS); Non-medical transportation (beyond the supplemental benefit level).⁵³

Income Limits Across Housing and Health Authorities⁵⁴

	Kentucky	New York
2016 Medicaid eligibility threshold (138% of Federal Poverty Level)	\$16,394 ⁴¹ statewide	\$16,394 ⁴² statewide
FY 2016 “Extremely low income” (the higher of 30% of the area median income or the federal poverty guidelines) threshold for HUD Section 8 Housing Choice Vouchers ⁴³ and other programs	\$11,880 in Harlan County, KY ⁴⁴	\$12,400 in Franklin County, NY ⁴⁵
	\$14,850 in Cincinnati, OH-KY-IN ⁴⁶	\$21,150 in Rockland County, NY ⁴⁷
FY 2016 “Very low income” (50% of the area median income) threshold for HUD Section 8 Housing Choice Vouchers ⁴⁸ and other programs	\$16,250 in Harlan County, KY ⁴⁹	\$20,650 in Franklin County, NY ⁵⁰
	\$24,750 in Cincinnati, OH-KY-IN ⁵¹	\$35,250 in Rockland County, NY ⁵²

North Carolina’s State-County Special Assistance

This is North Carolina’s Department of Health and Human Services’ program that provides cash supplements to individuals at risk of entering institutions.⁵⁵

North Carolina’s Targeted Unit Transition Program (TUTP)

This is a resource available for individuals who have a housing slot and who need immediate housing. In this program, individuals may be eligible to stay in a hotel for up to 90 days while they transition. TUTP provides up to \$400 per week to go towards a hotel stay.⁵⁶

North Carolina Housing Finance Agency’s Community Living Voucher

This voucher provides rental assistance to individuals with behavioral health disabilities who have been transitioned out of restrictive setting and into the community. The voucher is a partnership between the North Carolina’s Department of Health and Human Services and the state’s network of mental health management organizations. The voucher not only helps with rental assistance, but can also pay for security deposits and other costs associated with individuals’ housing needs. Finally, the Post Transition Team helps move people to their new setting and checks in on them three, six and twelve months post transition.⁵⁷

North Carolina’s Assertive Community Treatment Team

Assertive Community Treatment Team is a behavioral health team provided by North Carolina’s Department of Health and Human Services (DHHS), aimed at helping individuals live independently in the community. The team consists of psychiatrists, nurses, clinicians, peer support specialists, substance use specialists and vocational specialists and provides substance use disorder treatment, medication management, psycho-education, peer support, housing assistance, among other services.⁵⁸

North Carolina’s Individual Placement Support-Supported Employment (IPS-SE)

The Individual Placement Support-Supported Employment (IPS-SE) is under North Carolina's Division of Mental Health, Developmental Disabilities and Substance Abuse Services. This team focuses on helping individuals find and keep employment or return to school.⁵⁹

Ohio's Money Follows the Person Program - The Helping Ohians Move, Expanding Choice

Ohio's Money Follows the Person Program, "Helping Ohians Move, Expanding Choice" was established in 2008 and according to Ohio's Medicaid website ranks first nationally in transitioning individuals with mental illness into home and community settings and second in overall transitions completed. In nine years, the program transitioned more than 10,200 people to home and community settings.⁶⁰ Services offered by the Home-Choice Program include case management (before and after the transition), community transition services (for example help with the first month's rent), independent living skills training, community support coaching, among various other services.⁶¹

Ohio's Home Care Waiver

Ohio's Home Care Waiver provides services so that individuals with physical disabilities and unstable medical conditions can receive care in their homes instead of institutions such as nursing facilities, hospitals or rehabilitation facilities.⁶²

Ohio's Home Health Services

Home Health Services are Medicaid State Plan services that are provided to Medicaid recipients on a part-time basis. "Home health services include home health nursing, home health aide, and skilled therapies (physical therapy, occupational therapy, and speech-language pathology)."⁶³

Ohio's Recovery Requires a Community (RRAC) program

Recovery Requires a Community (RRCAC) program helps individuals diagnosed with mental health or substance use disorders, who may be transitioning from a Skilled Nursing Facility (SNF) to the community by providing financial assistance. Recovery funds can be used for short-term housing assistance, one-time utility payments or independent living assistance (personal care services or independent living skills training).⁶⁴

Wrap Around Services

Wrap around services are services designed to build independent living. These can include tenancy skills, assistance with integration into the community as well as connections to community-based health care, treatment and employment services.⁶⁵

¹ Bipartisan Policy Center. (2015) America's Growing Senior Population: Assessing the Dimensions of the Demographic Challenge. Retrieved from <http://bipartisanpolicy.org/wp-content/uploads/2015/09/BPC-Housing-Health-Senior-Population.pdf>

² World Health Organization. (2017) Social Determinants of Health. Retrieved from http://www.who.int/social_determinants/en/

³ Yale Global Health Leadership Institute. (2015) Leveraging the Social Determinants of Health: What Works? Retrieved from https://bluecrossmafoundation.org/sites/default/files/download/publication/Social_Equity_Report_Final.pdf

⁴ Healthy People. (2014). Social Determinants of Health. Retrieved from <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>

⁵ Urban Institute. (2015). The Housing Affordability Gap for Extremely Low-Income Renters in 2013 Retrieved from <https://www.urban.org/sites/default/files/publication/54106/2000260-The-Housing-Affordability-Gap-for-Extremely-Low-Income-Renters-2013.pdf>

⁶ University of California, San Francisco and Berkeley. (2017). The Impact of Cal MediConnect on Transitions from Institutional to Community-Based Settings. Retrieved from http://www.thescanfoundation.org/sites/default/files/the_impact_of_cal_mediconnect_on_transitions_from_institutional_to_community-based_settings_may_2017.pdf

⁷ The Kaiser Family Foundation. (2015) Financial and Administrative Alignment Demonstrations for Dual Eligible Beneficiaries Compared: States with Memoranda of Understanding Approved by CMS. Retrieved from <http://www.kff.org/medicaid/issue-brief/financial-alignment-demonstrations-for-dual-eligible-beneficiaries-compared/>

⁸ Joint Center for Housing Studies of Harvard University (2017). The State of the Nation's Housing. Retrieved from http://www.jchs.harvard.edu/sites/jchs.harvard.edu/files/harvard_jchs_state_of_the_nations_housing_2017.pdf

⁹ *Ibid.*

¹⁰ Center for Health Care Strategies, Inc. (2017). Design Considerations for Nursing Facility Quality Improvement Initiatives in Medicaid Managed Long-Term Services and Supports Programs Retrieved from https://www.chcs.org/media/Nursing-Facility-Quality-Improvement-MLTSS-Brief_082417.pdf

¹¹ Mercy Housing and The Low Income Investment Fund for The California Endowment and The Kresge Foundation. (2017). Innovative Models In Health And Housing. Retrieved from http://www.liifund.org/wp-content/uploads/2017/07/LIIF_whitepaper_pages.pdf

¹² Justice in Aging. (2017). Senior Poverty. Retrieved from <http://www.justiceinaging.org/take-action/senior-poverty/>

¹³ Justice in Aging. (2016). How to Prevent and End Homelessness Among Older Adults. Retrieved from <http://www.justiceinaging.org/wp-content/uploads/2016/04/Homelessness-Older-Adults.pdf>

¹⁴ *Ibid.*

¹⁵ Joint Center for Housing Studies of Harvard University. (2017). The State of the Nation's Housing. Retrieved from http://www.jchs.harvard.edu/sites/jchs.harvard.edu/files/harvard_jchs_state_of_the_nations_housing_2017.pdf

¹⁶ Technical Assistance Collaborative. (2015). Priced Out in 2014: The Housing Crisis for People with Disabilities. Retrieved from <http://www.tacinc.org/media/52012/Priced%20Out%20in%202014.pdf>

¹⁷ U.S. Department of Justice. Civil Rights Division. (2011). Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and *Olmstead v. L.C.* Retrieved from https://www.ada.gov/olmstead/q&a_olmstead.htm

¹⁸ The Kaiser Family Foundation. (2014). *Olmstead's Role in Community Integration for People with Disabilities Under Medicaid: 15 Years After the Supreme Court's Olmstead Decision.* Retrieved from <http://www.kff.org/report-section/olmsteads-role-in-community-integration-for-people-with-disabilities-under-medicaid-issue-brief/>

¹⁹ Center for Medicare and Medicaid Services. (2015). Coverage of Housing-Related Activities and Services for Individuals with Disabilities. Retrieved from <https://www.medicare.gov/federal-policy-guidance/downloads/cib-06-26-2015.pdf>

²⁰ MACPAC. (2014). Medicaid's Role in Providing Assistance with Long-Term Services and Supports. Retrieved from https://www.macpac.gov/wp-content/uploads/2015/01/Medicoids_Role_in_Providing_Assistance_with_Long-Term_Services_and_Supports.pdf

²¹ Center for Medicare and Medicaid Services. (2015). Coverage of Housing-Related Activities and Services for Individuals with Disabilities. Retrieved from <https://www.medicare.gov/federal-policy-guidance/downloads/cib-06-26-2015.pdf>

²² *Ibid.*

²³ The Kaiser Family Foundation <https://www.kff.org/report-section/money-follows-the-person-a-2015-state-survey-of-transitions-services-and-costs-report/>

²⁴ Center for Medicare and Medicaid Services. (2015). Coverage of Housing-Related Activities and Services for Individuals with Disabilities. Retrieved from <https://www.medicare.gov/federal-policy-guidance/downloads/cib-06-26-2015.pdf>

²⁵ Center on Budget and Policy Priorities. (2016). States Are Using Flexibility to Create Successful, Innovative Medicaid Programs. Retrieved from <https://www.cbpp.org/research/health/states-are-using-flexibility-to-create-successful-innovative-medicoid-programs>

²⁶ The Kaiser Family Foundation. (2016). Money Follows the Person Demonstrations. Retrieved from <http://www.kff.org/medicaid/state-indicator/money-follows-the-person-demonstrations/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Operational%22,%22sort%22:%22asc%22%7D>

²⁷ The Kaiser Family Foundation. (2014). *Olmstead's Role in Community Integration for People with Disabilities Under Medicaid: 15 Years After the Supreme Court's Olmstead Decision.* Retrieved from <http://www.kff.org/report-section/olmsteads-role-in-community-integration-for-people-with-disabilities-under-medicoid-issue-brief>

²⁸ Technical Assistance Collaborative. (2012). Federal Housing Resources Guide. Retrieved from <http://www.tacinc.org/media/27844/Federal%20Housing%20Programs.pdf>

²⁹ National Academy for State Health Policy. (2017). Federal and State Collaboration to Improve Health through Housing. Retrieved from <http://nashp.org/wp-content/uploads/2017/01/Health-and-Housing-Brief.pdf>

³⁰ National Low Income Housing Coalition. Section 202: Supportive Housing for the Elderly. Retrieved from http://nlihc.org/sites/default/files/AG-2017/2017AG_Ch04-S07_Section-202.pdf

³¹ Housing. Housing for the Elderly (Section 202). Retrieved from https://www.hud.gov/sites/documents/26-HSNG.FOR_THE_ELDERLY.PDF

³² U.S. Department of Housing and Urban Development. Section 811 Supportive Housing for Persons with Disabilities. Retrieved from https://portal.hud.gov/hudportal/HUD?src=/program_offices/housing/mfh/progdesc/disab811

³³ Technical Assistance Collaborative. Section 811 Frequently Asked Questions (FAQs). Retrieved from

http://811resourcecenter.tacinc.org/media/14398/faqs_part_one.pdf

³⁴ Center for Healthcare Strategies, Inc. (2016). Housing Options for High-Need Dually Eligible Individuals: Health Plan of San Mateo Pilot. Retrieved from <https://www.chcs.org/media/HPSM-CCS-Pilot-Profile-032916.pdf>

³⁵ *Ibid.*

³⁶ *Ibid.*

³⁷ *Ibid.*

³⁸ CareSource. (2016). Annual Report. Retrieved from <https://www.caresource.com/documents/2016-annual-report/>

³⁹ Inland Empire Health Plan. (2017). Returning Home: How IEHP transitions Members back to the community. Retrieved from <https://ww3.iehp.org/~media/Marketing/Files/Member/English/Plans-and-Benefits/Medi-Cal/August-2017/Custodial-Care--Success-Stories2017-V10final.pdf>

⁴⁰ Cardinal Innovations Healthcare. (2016). Transitions to Community Living FAQ. Retrieved from <https://www.cardinalinnovations.org/docs/transitions-to-community-living-frequently-asked-questions.pdf>

⁴¹ Americans with Disabilities Act. North Carolina ADA Agreement Fact Sheet. Retrieved from <https://www.ada.gov/olmstead/documents/nc-factsheet-olmstead.pdf>

⁴² California Long Term Care Education Center. (2017). Proposal for L.A. Care on Home Health Care Integration Program.

⁴³ American Association of Retired Person. (2016). Family Caregivers and Managed Long-Term Services and Supports. Retrieved from http://www.aarp.org/content/dam/aarp/ppi/201608/AARP1080_FSandMLTSS_REPORT_WEB.pdf

⁴⁴ Medicaid. Balancing Incentive Program. Retrieved from <https://www.medicaid.gov/medicaid/ltss/balancing/incentive/index.html>

⁴⁵ The Kaiser Family Foundation. (2015). Medicaid Balancing Incentive Program: A Survey of Participating States. Retrieved from <http://www.kff.org/report-section/medicaid-balancing-incentive-program-a-survey-of-participating-states-report/>

⁴⁶ California Department of Health Care Services. (2017). Assisted Living Waiver. Retrieved from <http://www.dhcs.ca.gov/services/ltc/Pages/AssistedLivingWaiver.aspx>

⁴⁷ Paying for Senior Care. Understanding Your Financial Options for Long Term Care. (2017). Medi-Cal Assisted Living Waiver. Retrieved from <https://www.payingforseniorcare.com/medicaid-waivers/ca-assisted-living-waiver.html>

⁴⁸ California Department of Health Services. (2017). Community Based Adult Services. Retrieved from [http://www.dhcs.ca.gov/services/Pages/Community-BasedAdultServices\(CBAS\)AdultDayHealthCare\(ADHC\)Transition.aspx](http://www.dhcs.ca.gov/services/Pages/Community-BasedAdultServices(CBAS)AdultDayHealthCare(ADHC)Transition.aspx)

⁴⁹ California Department of Health Care Services. Training Module 2: Overview of the California Community Transitions (CCT) a Money Follows the Person (MFP) Program. Retrieved from http://www.dhcs.ca.gov/services/ltc/Documents/CCT_TM2_CCTOverview.pdf

⁵⁰ State of California. Department of Developmental Services. (2017). In-Home Supportive Services. Retrieved from <http://www.dds.ca.gov/SupportSvcs/IHSS.cfm>

⁵¹ Partners in Care Foundation. Multipurpose Senior Services Program. Retrieved from <https://www.picf.org/multipurpose-senior-services-program-mssp/>

⁵² California Department of Aging. Multipurpose Senior Services Program. Retrieved from http://www.aging.ca.gov/ProgramsProviders/MSSP/Program_Overview.aspx

⁵³ Cal Duals. (2013). Coordinated Care Initiative (CCI): Cal MediConnect Policy for Cal MediConnect: Care Plan Option services (CPO services). Retrieved from <http://calduals.org/wp-content/uploads/2013/06/Demo-CPO-services-Paper-6.3.13.pdf>

⁵⁴ National Academy for State Health Policy. (2017). Federal and State Collaboration to Improve Health through Housing. Retrieved from <http://nashp.org/wp-content/uploads/2017/01/Health-and-Housing-Brief.pdf>

⁵⁵ North Carolina Department of Health and Human Services. State-County Special Assistance, In Home. Retrieved from <https://www.ncdhhs.gov/assistance/adult-services/state-county-special-assistance-in-home>

⁵⁶ North Carolina Transition to Community Living. (2016). Housing Fund Guidelines. Retrieved from https://files.nc.gov/ncdhhs/documents/files/Housing-Fund-Guidelines_Nov2016.pdf

⁵⁷ North Carolina Housing Finance Agency. Community Living Programs. Retrieved from <https://www.nchfa.com/community-living-programs>

⁵⁸ Cardinal Innovations Healthcare. (2017). Assertive Community Treatment Plan. Retrieved from <https://www.cardinalinnovations.org/clinical-design-plan/continua-of-care-overview-service-array-summaries/mh-sa-continua-summary/adult-mental-health-continuum/assertive-community-treatment-team>

⁵⁹ NC Division of Mental Health, Developmental Disabilities & Substance Abuse Services. (2016). Individual Placement and Support Supported Employment (IPS-SE) for AMH/ASA. Retrieved from <https://ncdhhs.s3.amazonaws.com/s3fs-public/documents/files/State-Funded%20IPS-SE%20for%20AMH-SAS%20FINAL%20for%20POSTING%201-27-16.doc.pdf>

⁶⁰ Ohio Department of Medicaid. HOME Choice: Helping Ohioans Move, Expanding Choice. Retrieved from <http://www.medicaid.ohio.gov/FOROHIOANS/Programs/HomeChoice.aspx>

⁶¹ Ohio Department of Medicaid. Home Choice. Retrieved from <http://www.medicaid.ohio.gov/Portals/0/Resources/Publications/Materials/HomeChoiceFactSheet.pdf?ver=2017-07-25-095320-450>

⁶² Ohio Department of Medicaid. The Ohio Home Care Waiver. Retrieved from <http://www.medicaid.ohio.gov/FOROHIOANS/Programs/OhioHomeCareWaiver.aspx>

⁶³ Ohio Department of Medicaid. Home Health Services. Retrieved from <http://www.medicaid.ohio.gov/PROVIDERS/ProviderTypes/HomeHealthServices.aspx>

⁶⁴ Ohio Mental Health and Addiction Services. (2017). Recovery Requires a Community. Retrieved from <http://mha.ohio.gov/Default.aspx?tabid=816#29221189-what-kinds-of-services-can-be-applied-for-through-recovery-requires-a-community->

⁶⁵ United States Interagency Council on Homelessness. Supportive Housing. Retrieved from <https://www.usich.gov/solutions/housing/supportive-housing>