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# Using Medi-Cal to Fund Services in Supportive Housing

Prepared for CSH by Kate Durham

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## INTRODUCTION

### **Supportive Housing**

Supportive housing works to end homelessness. It is proven to help formerly homeless, low-income individuals and families who face the most complex challenges—including substance abuse, mental illness, and HIV/AIDS—live more stable, productive lives.

Supportive housing is successful because it combines three key elements: affordable housing, support services and community. Inherent in the model is the provision of flexible and responsive services that individuals and families may need to move towards health and self-sufficiency.

Research and experience confirm the “but-for” argument that links housing with services:

*But for housing, this population would not access or effectively use services.  
But for these services, they would not get and maintain their housing.*

Without a stable place to live and a support system to help them address their underlying problems, this population of homeless people tends to bounce from one emergency system to the next—from the streets to shelters to public hospitals to psychiatric institutions and detox centers and back to the streets. This cycle has extremely high costs, both human and economic.

In contrast, supportive housing has a positive impact on health. Studies show that tenants in supportive housing have:

- Decreases of more than 50% in emergency room visits and hospital inpatient days
- Decreases in use of emergency detoxification services by more than 80%
- Increases in the use of preventive health care services

Research also shows that providing someone with supportive housing costs essentially the same amount of money as it does to keep that person homeless and stuck in the revolving door of high-cost crisis care and emergency shelter. So, it boils down to a choice: waste money keeping people homeless or spend those same dollars on a long-term solution that produces positive results for individuals, families, and communities.

Supportive housing is cost effective and it works. For these reasons, we must advance the model by identifying strategies and means to fund its development, operations, and services.

## Medi-Cal Financing

In 2002, CSH initiated an ongoing project to study how Medicaid funds can be used to fund services in supportive housing. Our research is documented in a series of white papers that are available for download at:

<http://www.csh.org/index.cfm?fuseaction=Page.viewPage&pageID=458>

This document is the result of research that focused specifically on the application of Medi-Cal (the State of California’s implementation of Medicaid) to services in supportive housing. Three Medi-Cal reimbursement options—Specialty Mental Health Services Targeted Case Management (TCM), Specialty Mental Health Services Rehabilitation Option, and Federally Qualified Health Centers (FQHC)—offer promising strategies. The goal of supportive housing is consistent with the goal of these programs: to manage the health of low-income people in the community and reduce their dependence on high-end care.

Medi-Cal is funded through a combination of federal financial participation (FFP) and “state” or non-federal share of costs. For some benefits, TCM and mental health services under the rehabilitation option for example, the “state” share of costs is paid by counties and therefore a partnership with the County is required to access these funds. The state pays the non-federal share of cost of services provided by FQHCs.

This paper is not intended to be **the** authoritative document on utilizing Medi-Cal to fund services in Supportive Housing. Rather, its intention is to provide a broad overview that assists current and prospective supportive housing providers and local government staff in exploring whether any of these reimbursement options are a suitable fit for your supportive housing projects. Its content was gathered from research and interviews with providers who have successfully used Medi-Cal to pay for services in supportive housing.

You can use this tool in a number of ways. The chart gives an at-a-glance checklist to guide you in identifying which if any of the three Medi-Cal reimbursement options are most suitable for your organization. The chart is followed by a chapter on each of the three funding streams:

1. Targeted Case Management (TCM)
2. Rehabilitative Mental Health (Rehab Option)
3. Federally Qualified Health Centers (FQHC)

You may decide to

- read a section in full,
- consult the overview only, which broadly describes the funding stream and how it may be applied to services in supportive housing,

- select particular sub-sections (what does this funding cover? which populations are served? what does this funding entail? and so on),
- refer to the checklist, which gives pointers in relation to guided questions,
- consider the resource list for links to more detailed or technical information, or
- read the case studies to get a sense of Medi-Cal funding in practice.

Reading the entire document will give you a basic, comparative understanding of the issues involved and factors to consider in exploring Medi-Cal as a funding strategy for services in supportive housing.

**CHART: Which Medi-Cal funding mechanism is appropriate for your supportive housing project?**

	<b>Targeted Case Management (TCM)</b>	<b>Rehabilitative Mental Health (Rehab Option)</b>	<b>Certify as a Federally Qualified Health Center (FQHC) or partner with an existing FQHC</b>
<b>Your tenants:</b>	Your tenants are Medi-Cal beneficiaries or Medi-Cal eligible.	Your tenants are Medi-Cal beneficiaries or Medi-Cal eligible.	Your tenants are registered Medicare or Medi-Cal beneficiaries or Medi-Cal eligible.
	Your tenant population is mixed (mental health tenants not overly represented).	A significant percentage of your tenants have mental disabilities, diagnoses of which are included in the DSM IV, and their needs fulfill medical necessity criteria for mental health services.	Your tenants have complex and chronic medical and behavioral health issues and are in need of comprehensive primary health care
<b>Your services:</b>	Your services include targeted case management services (assessment, linkage and referral, crisis management planning, etc).	Mental health services are a focus of your service program.	Primary health care services are a focus of your service program, and mental health services are provided by a licensed mental health professional.
	Your supportive housing project is not service rich; you primarily broker outside services on behalf of your tenants.	You provide (or are willing to provide) services using a clinical model.	Your service model, or that of your partner agency, includes the use of licensed medical and psychiatric providers.
<b>Your agency or service partner staff:</b>	Your staff primarily includes experienced case managers or service coordinators.	Your staff include licensed mental health providers (LMHP) such as clinical psychologists; clinical social workers; marriage and family therapists; and registered nurses as well as staff who meet California's mental health rehabilitation specialist qualifications.	Your staff includes licensed practitioners such as physicians, psychiatrists, clinical psychologists or licensed social works; or mid-level practitioners such as nurse practitioners.
<b>Your infrastructure:</b>	You have or will create the infrastructure to document TCM services accurately and consistently.	You have or will create systems to document medical necessity and assessment, diagnosis, and treatment plan for tenants served.	You have or will create systems to document medical necessity and assessment, diagnosis, and treatment plan for tenants served.
<b>Your partnerships:</b>	<i>Funding Relationship:</i> You have (or will pursue) a current contract with your Local Government Authority (typically County Health or Human Services Department).	<i>Funding Relationship:</i> Your organization has (or will pursue) a contract with County Mental Health or Behavioral Health	<i>Service Provision Partnership:</i> You have or would like to pursue a partnership with a local FQHC to provide comprehensive primary health care to your tenants

# TARGETED CASE MANAGEMENT (TCM)

## Contents

OVERVIEW: What is Targeted Case Management (TCM) funding?

CHECKLIST: Is TCM an appropriate funding stream for you?

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## **OVERVIEW: What is Targeted Case Management (TCM) funding?**

TCM is a partial federal reimbursement for specialized, comprehensive case management services that assist federally qualified Medi-Cal eligible individuals in a defined target population to gain access to needed medical, social, educational, and other services. Like the mental health rehabilitation option, TCM falls under Medi-Cal's Specialty Mental Health Services. To qualify for TCM reimbursement, you need to have a contract with the local government authority (LGA), which is responsible in turn to the state. The LGA is the County or chartered city, the entity that contracts directly with the California Department of Health Services to administer and provide TCM. In lay terms, the LGA is the faucet for TCM.

TCM funds are intended to ensure that the changing needs of eligible individuals are addressed on an ongoing basis and that appropriate choices are provided among the widest array of options for meeting those needs.

TCM services can address risks, needs, and goals that are not as narrowly defined on the basis of medical or psychiatric diagnosis as other Medi-Cal mental health financing. TCM may be a good source of funding for case management services in supportive housing, particularly for those projects whose service providers are not licensed medical clinics or mental health specialists, and whose on-site case management focuses primarily on assessment and ongoing linkage/brokerage of other services within the

broader community. Depending upon your tenant eligibility requirements, your supportive housing tenants may have special health needs that would benefit from the comprehensive case management services covered under TCM. In addition, the on-site service coordination provided may be consistent with TCM requirements.

TCM requires sophisticated documentation, and auditing requirements are stringent. Organizations must have infrastructure in place to successfully manage TCM. Detailed case files and comprehensive, well-documented assessments and service plans must be completed for individual clients. This kind of detail is more feasible where tenants are relatively stable than with a more transient population. While infrastructure demands are significant and initial development of the internal systems necessary to manage TCM are time- and resource-consuming, maintaining the systems once established can become routine. The rigors of administering TCM can support best practices within organizations providing services in supportive housing.

**CHECKLIST: Is TCM an appropriate funding stream for you?**

<p>1. Do you currently provide targeted case management services including assessment, service plan development, linkage and referral, crisis management planning, and periodic evaluation?</p>	<p><b><i>Because direct services such as counseling or translation are not funded under TCM, this funding stream is not likely to cover all of the case management services that you provide.</i></b></p>
<p>2. Do you currently serve a Medi-Cal eligible population? What percentage of those you currently serve are Medi-Cal beneficiaries?</p>	<p>It may only be worth your while to take on the necessary reporting and documenting if this is a significant percentage.</p>
<p>3. What are the costs of providing your <i>targeted</i> case management services?</p>	<p>Again, these costs should be significant to warrant the effort of securing TCM funding.</p>
<p>4. What funding sources currently cover your <i>targeted</i> case management services? Can you certify 100% match from allowable funding sources?</p>	<p>You need to ensure 100% match from a non-federal certified public agency. The match cannot be from a private source nor can match funds be used as match for something else.</p>
<p>5. Does your case management staff meet Community State Plan Amendment (SPA) qualifications?</p>	<p>Staff must have a combination of recognized degree, experience, and/or agency-approved case-management training.</p>
<p>6. Do you have a contract with your local government authority (LGA)?</p>	<p>TCM funds can only be sourced through a contract with your LGA, so you need to have a contract in place or make one.</p>

<p>7. How well do you currently document your services for each individual client? Do you have the infrastructure, or can you build and sustain the infrastructure needed to accurately and consistently document TCM services?</p>	<p>To meet federal requirements for TCM reimbursement, you need to record a time survey over a month period that will be annualized as well as keep cost reports, encounter documentation, and a non-duplication/ performance-monitoring plan.</p>
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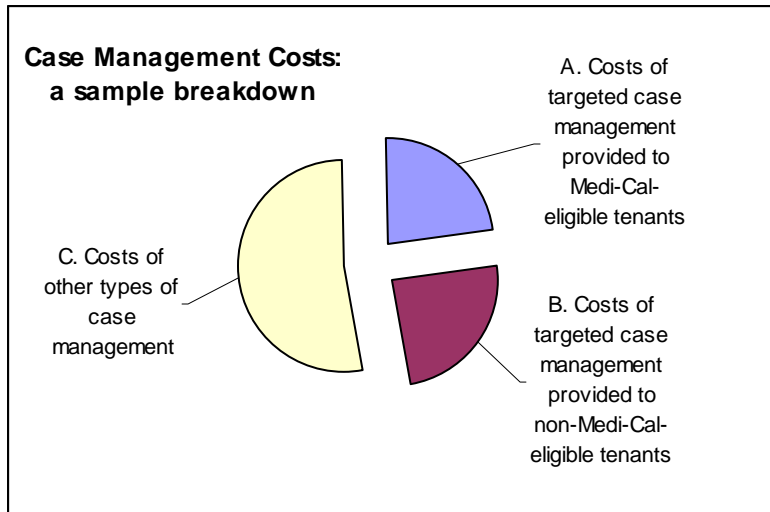
**SERVICES: What do TCM funds cover?**

TCM reimburses for the specific allowable, billable activities listed below. Direct services, such as counseling or translation, are not funded under TCM.

- Preparing a Needs Assessment that documents medical/mental conditions; vocational/educational needs; physical needs; social/emotional status; housing/physical environment; and familial/social support systems.
- Developing a Service Plan—written, comprehensive, individualized—that describes actions required to meet service needs; persons and/or agencies to which beneficiary will be referred; and the nature, frequency, and duration of the activities and specific strategies undertaken to achieve service outcomes.
- Providing Linkage, Consultation, and/or Referral including interim referrals to other persons/providers/agencies, as well as follow-up on previous referrals. Follow-up must be within thirty days of a scheduled referral appointment.
- Assisting with Accessing Services, including making appointments and arranging transportation or translation.
- Planning Crisis Assistance, including evaluating, coordinating, and arranging immediate services to avoid, eliminate, or reduce crisis situations.
- Conducting Periodic Review/Evaluation of client’s progress toward achieving objectives identified in their service plan, at least once every six months, by the case manager in consultation with the beneficiary.

To be allowable, these service components must be *properly documented* and provided to *eligible clients* by *qualified staff*.

Because direct counseling or translation services, for example, are not billable activities under TCM, this funding stream is not likely to cover all of the case management services that your organization provides, as demonstrated by the fictitious example below.



Only the costs shown as “A” in the chart are covered by Medi-Cal TCM funds.

### **POPULATIONS: Who is served by TCM funds?**

Six amendments to the California State Plan (the comprehensive document that describes the state’s Medicaid program) define distinct target populations eligible to receive TCM services. These populations correlate with six distinct TCM programs: Public Health, Public Guardian, Adult Probation, Outpatient Clinics, Linkages, and (our focus) Community. The Community State Plan Amendment (SPA) allows community-based organizations (CBOs) to contract with local government authorities (LGAs) to provide TCM services. The target population, as defined in the Community SPA, is:

*Medi-Cal eligible adults or children at risk of abuse and unfavorable developmental, psychological, or social outcomes including the following: 1) persons abusing alcohol, drugs or both; 2) persons at risk of physical, sexual, or emotional abuse; and/or 3) persons at risk of neglect.*

### **PROVIDERS: Who may provide TCM-funded services?**

Community TCM services must be provided by an individual case manager who:

- holds a BA degree from an accredited college or university, and has completed agency approved case management training; or
- holds an AA degree from an accredited college or university, has completed approved case management training, and has had two years of case-management experience; or
- has completed agency-approved case-management training and has had at least four years of case management experience.

There is no state-wide definition of agency-approved case-management training. Each LGA makes its own definition.

### **REQUIREMENTS: What does TCM funding entail?**

As with all Medi-Cal services, TCM reimbursement claims must be fully documented. In order to meet state and federal requirements, the following paperwork and procedures must be in place:

- **Time Survey:** Each year, the California Department of Health Services designates a month in which LGAs participate in a TCM time survey to document the percentage of time/resources spent on activities related to the provision of TCM. Information from the time survey is then aggregated into an annual cost report.
- **Cost Report:** The cost report reflects allowable TCM expenditures from the prior fiscal year and is based on the annual TCM time survey. These actual costs and encounter data determine the annual per-encounter reimbursement rate for the current fiscal year.
- **Encounter Documentation:** An encounter is a face-to-face contact with a Medi-Cal beneficiary for the purpose of rendering one or more TCM service components. Typically, encounters represent one unit of service. Encounters are not defined by time; a single encounter could be one minute or one hour. Extensive documentation, defined by state and federal regulations as well as by each individual LGA, must back each encounter.
- **Billable Encounter Rate:** The rate paid for each TCM encounter; this loads in all the costs of providing TCM activities, including the indirect costs. Within each LGA, each SPA is represented by only one cost report, and therefore one encounter rate. Each LGA can determine how much of the reimbursement it passes on to contracting organizations. The cost report caps the number of encounters that will be reimbursed for the current fiscal year; conducting encounters beyond the cap will not result in more funding. San Francisco's encounter rate under community SPA, as an example, is \$218.
- **Non-Duplication/Performance Monitoring Plan:** This TCM compliance plan includes procedures for ensuring non-duplication of TCM services. Protocol requires that information be requested from client during the initial intake process about whether or not he/she is receiving TCM services from another provider(s). If there is possible duplication, providers must follow up to establish which agency has primary responsibility.

### **REIMBURSEMENT: How does TCM work?**

The TCM Federal Medical Assistance Percentage (FMAP) rate is set by the federal government annually. Generally, it is around 50% for provision of those TCM services

included in the State Plan. To access TCM dollars, local government authorities must match federal dollars with non-federal certified public expenditures that are not claimed as match for any other funding source.

TCM providers are limited to LGAs under contract with Department of Health Services to provide TCM services. To participate in TCM, LGAs must have a current, signed TCM Provider Agreement. They can then provide TCM services directly, or contract with other public agencies or community-based organizations (CBOs) to provide TCM on their behalf. The primary relationship, however, will always be between the State and the LGA. CBOs cannot contract directly with the state to provide services.

**CASE STUDY:** This is how one California County contracts with a CBO to provide TCM services:

*A County health department (the LGA) contracts with a CBO for \$100,000 from its general fund to provide targeted case management services in a family supportive housing project. Comprehensive case management services are provided by qualified staff to Medi-Cal beneficiaries. If TCM is successfully accessed, the federal government will reimburse the County 50% of its \$100,000 disbursement, or \$50,000. Of this \$50,000, the County health department takes 12% off the top to cover the administrative costs of managing TCM. (Note that LGAs establish their own administrative fees and can, if they choose, keep the entire reimbursement.) The remaining 88% (or \$44,000) in this case is provided to the CBO to fund services in supportive housing. Because the County had to spend \$100,000 to be reimbursed \$50,000, TCM funding in this example is considered to be an augmentation, rather than a replacement of one funding source for another.*

<i>What</i>	<i>Percentage/ Calculation</i>	<i>Amount</i>
<i>County Health Dept contracts with CBO to provide TCM services</i>		<i>\$100,000</i>
<i>Federal reimburses County Health Dept</i>	<i>50% of \$100,000</i>	<i>\$50,000</i>
<i>County Health Dept takes administrative costs</i>	<i>12% of \$50,000</i>	<i>\$6,000</i>
<i>CBO receives as service reimbursement</i>	<i>88% of \$50,000</i>	<i>\$44,000</i>
<i>County Health Dept contributes to CBO in total</i>	<i>Original \$100,000 plus 88% of reimbursement</i>	<i>\$144,000</i>

As the case study illustrates, an LGA may enter into an agreement with a contracting CBO to provide TCM services under the Community SPA. This makes it possible, essentially, for the LGA to *buy* more services in supportive housing without expending more funds. However, this scenario is unusual. The LGA is under no mandate to pass on its TCM reimbursement to the CBO. If it chooses, the LGA can retain any percentage of its reimbursement to cover both the cost of purchasing TCM services from the provider as well as the administrative costs of managing TCM.

**PARTNERSHIP: How should you approach your LGA?**

If you think you may be a good match for TCM and you already have a contract with your County, then you should approach the County with a request to explore the possibility of partnering to access TCM funding. If you think you may be a good match for TCM but you do not already have a contract with the County, the following may be a strategic way to approach your County.

*Your organization provides TCM services in a single adult supportive housing project in which most tenants are enrolled in Medi-Cal. These services are provided by qualified staff to Medi-Cal beneficiaries and are currently paid for with state funding that expires at the end of the year. You do not currently have a contract with your County but believe that the County should be involved in funding services in supportive housing, particularly given your project’s documented success at reducing tenants’ reliance on local high-end systems of care. Having done a thorough investigation into TCM, you approach your County health department with a request to jointly explore TCM funding. You explain to the County that if they contracted with your organization for \$100,000 to provide targeted case management services, and if together you successfully accessed TCM funding at 50%, the County would be reimbursed \$50,000 and, in effect, buy \$100,000 worth of case management services for \$50,000.*

<i>What</i>	<i>Percentage/ Calculation</i>	<i>Amount</i>
<i>County Health Dept contracts with CBO to provide TCM services (probably represents only a portion of overall contract)</i>		<i>\$100,000</i>
<i>Federal reimburses County Health Dept</i>	<i>50% of \$100,000</i>	<i>\$50,000</i>
<i>County Health Dept takes full reimbursement</i>	<i>100% of \$50,000</i>	<i>\$50,000</i>
<i>Net Cost to County Health Dept of buying \$100,00 worth of targeted case management services</i>	<i>\$100,000 - \$50,000</i>	<i>\$50,000</i>

If your County recognizes supportive housing as an effective solution to homelessness, this may be a cost-effective strategy to support and sustain services.

To minimize audit exceptions, an LGA is likely to want confirmation of the following before deciding to partner with a CBO to provide TCM services:

- Does the organization provide comprehensive case management to a Medi-Cal eligible population?
- Can the organization handle TCM's rigorous administrative requirements?

Every LGA has a Medi-Cal Administrative Activities (MAA) and TCM coordinator who, typically works in the County Health Department. To find out more about coordination in your County, consult these sites:

- [www.maa-tcm.net](http://www.maa-tcm.net)
- [www.dhs.ca.gov/maa/tcmprogramdescription.htm](http://www.dhs.ca.gov/maa/tcmprogramdescription.htm)

#### **RESOURCES: Where can you read more about TCM?**

Overview, Corporation for Supportive Housing white paper:

<http://documents.csh.org/documents/policy/Med/MedicaidOpportunities.doc>

California LGA Consortium for Medi-Cal Administrative Activities (MAA) and Targeted Case Management (TCM):

[www.maa-tcm.net](http://www.maa-tcm.net)

California Department of Health Services TCM Program Description:

[www.dhs.ca.gov/maa/tcmprogramdescription.htm](http://www.dhs.ca.gov/maa/tcmprogramdescription.htm)

## REHABILITATIVE MENTAL HEALTH (REHAB OPTION)

**OVERVIEW:** What is the Rehabilitative Mental Health Services option?

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**SERVICES:** What do Rehabilitative Mental Health funds cover?

**POPULATIONS:** Who is served by Rehabilitative Mental Health?

**PROVIDERS:** Who may provide Rehabilitative Mental Health services?

**REQUIREMENTS:** What does Rehabilitative Mental Health funding entail?

**REIMBURSEMENT:** How does Rehabilitative Mental Health funding work?

**PARTNERSHIP:** What kind of partnership does Rehabilitative Mental Health require?

**RESOURCES:** Where can you read more about Rehabilitative Mental Health?

### **OVERVIEW: What is the Rehabilitative Mental Health Services option?**

Medi-Cal's Specialty Mental Health Services rehabilitation option provides services for eligible Medi-Cal beneficiaries. These services must be directed by licensed mental health practitioners, may be provided almost anywhere in the community, and are focused on both the treatment of the mental disorder and the associated function limitations that may jeopardize individuals' ability to live independently in the community. California counties differ in their approach to providing these services: some contract private organizations to provide all specialty mental health services, some provide all care themselves, and others do a combination of the two.

To qualify for reimbursement, services must be determined to be medically necessary by a certified provider at its certified location, under contract with the County's Department of Mental Health or Behavioral Health Services. To qualify as medically necessary in California, services must meet the three following criteria:

1. the client's diagnosis must be one of those listed in the DSM IV (or most current version of the DSM);
2. the client must have a significant impairment—and/ or a probability of significant deterioration—in an important area of life functioning; and
3. the proposed intervention must specifically address that impairment, which is deemed unresponsive to physical healthcare treatment.

There is significant overlap between supportive housing populations and the intended beneficiaries of these services: people who are low-income and in need of mental health care in order to recover and/or maintain social functioning that is impaired by mental illness. Services covered under the rehabilitation option include many of the

components of supportive housing service models including mental illness symptom management, healthy lifestyle and household skills development, and relapse prevention. Given that target population and services overlap, combined with the fact that this funding stream covers services in non-institutional settings, these funds may well be appropriate to pay for a range of services for Medi-Cal eligible tenants living in supportive housing.

However, of the three funding streams explored in this document, this one is the most restrictive in its requirements. Services covered under the Medi-Cal mental health rehab option may be provided only to tenants with a serious, diagnosed mental illness. Therefore, this option is less applicable to supportive housing projects that serve a broader tenant population.

**CHECKLIST: Is Rehabilitative Mental Health an appropriate funding stream for you?**

1. Does your organization have a contract with your County Mental Health or Behavioral Health Department? Are you willing/able to pursue such a contract?	These funds are only available through a contract with your County Mental Health or Behavioral Health Department.
2. Do you currently provide mental health services to your tenants, or do you intend to in future?	This stream is appropriate if mental health services are a focus of your program. To qualify may involve a significant shift in the culture of your organization, towards a more clinical model.
3. Do you currently serve a Medi-Cal population? What percentage of those you currently serve are Medi-Cal beneficiaries?	It may only be worthwhile to take on the administrative costs and requirements if this is a significant percentage.
4. How many of your tenants' specialty mental health needs qualify as medically necessary?	This stream may only be worth pursuing if a significant percentage of your tenants' needs in this area fulfill the criteria for medical necessity* (including one of the listed diagnoses in the DSM- IV).
5. Do you have licensed clinicians on staff? Do you have a location certified by the County for mental health services?	Location certification, one of the requirements for access to these funds, is issued to a licensed mental health professional. Providers must be either licensed mental health professionals (LMHPs) or eligible for waivers.
6. Does your staff maintain thorough documentation?	You need strong administrative structures in place or be willing to establish and maintain them.
7. Are you the sponsor or service provider for several supportive housing projects?	Given economies of scale this funding can be maximized across a number of venues.

\* Medical Necessity: Individual is diagnosed with one of a list of specified disorders and has a significant impairment, or a probability of significant deterioration, in an important area of life functioning.

## **SERVICES: What do Rehabilitative Mental Health funds cover?**

Mental health rehabilitation funds cover services within Medicaid's definition of rehabilitation: those services that assist in restoring the skills and/or functions that have been lost as a result of psychiatric disability. Covered services include individual and group mental health services, crisis intervention and stabilization, medication management, day treatment and rehabilitation services, and short-term or ongoing crisis residential treatment. Not all covered services—crisis residential treatment, for example—are appropriate to supportive housing environments.

Service activities may include, among others:

**Assessment:** which includes a clinical analysis of the history and current status of a beneficiary's mental, emotional or behavioral disorder;

**Plan development:** which includes development and/or monitoring of a service plan;

**Therapy:** which includes individual, group and/or family therapy at which the beneficiary is present;

**Rehabilitation:** which includes assistance in improving, maintaining or restoring a beneficiary's functional, daily living and social skills and assistance with restoring communication and socialization skills—including the skills needed to work—that may have been impaired as a result of mental illness;

**Collateral:** which includes the provision of services to a significant person in the beneficiary's life, or consultation on behalf of the beneficiary with other established service providers with the intent to improve or maintain the health of the beneficiary.

## **POPULATIONS: Who is served by Rehabilitative Mental Health?**

Services under the rehabilitation option are intended to serve Medi-Cal eligible individuals: specifically low-income individuals with mental disabilities whose diagnoses are included in the DSM IV.

Because pursuing this funding only makes sense if a significant percentage of your tenants are eligible for and in need of mental health rehab services, it is worth assessing the percentage of tenants in your project(s) who will qualify. Your assessment should include how many tenants are Medi-Cal eligible and, of those, how many meet the medical necessity qualification (see definition of medical necessity on previous page).

## **PROVIDERS: Who may provide Rehabilitative Mental Health services?**

Rehabilitative mental health services must be provided by licensed mental health professionals (LMHPs) who may include physicians; clinical psychologists; clinical social workers; marriage, marriage and family therapists; registered nurses; vocational nurses, and psychiatric technicians, all of whom must be licensed or registered in their field.

States exert a degree of flexibility on waiver regulations: paraprofessionals and peer staff may qualify on the basis of experience and on-the-job training as a substitute for degree requirements. For example, in California mental health rehabilitation specialists (MHRS) who have a BA/BS and four years of experience in a mental health setting as specialists in the fields of physical restoration, social adjustment or vocational adjustment may provide covered services. Up to two years of graduate professional education may be substituted for the experience requirement on a year for year basis. To qualify for reimbursement, however, licensed staff must complete diagnosis and provide ongoing clinical oversight for services provided by mental health rehabilitation specialists.

## **REQUIREMENTS: What does Rehabilitative Mental Health funding entail?**

Site certification is required, for which you need a physical address and a distinct physical space to keep files. The certification is issued through, and to, a licensed person working within your organization. Some counties allow certified locations to conduct work in the field. For example, in certain counties, if your organization is the sponsor/service provider for several supportive housing projects, you may certify one location and apply that single certification across sites.

Medi-Cal rehabilitative mental health services funds are designed to reimburse the provision of *therapeutic* services that restore functioning impaired by a psychological disorder. To offer and document services in a way that qualifies for these funds may involve a change in organizational culture. This funding stream entails significant administrative support to meet documentation requirements. Providers are required to maintain client records in a manner consistent with state and federal law. To demonstrate billable activity, for example, every contact must be charted in detailed notes, which include the reason for the contact. Upon audit, lack of standard and required documentation may result in having to pay back service reimbursement.

**CASE STUDY:** Raising the bar on service delivery and documentation can make good clinical and programmatic sense, moving an organization towards higher standards and best practices. One California program has integrated the requirements of this funding stream into ongoing organizational development.

*Good training and ongoing supervision are key. We pushed cultural changes within the organization from the beginning—if you don't do this at the start, it is much harder to change. We made documentation a part of staff evaluations, with performance measures, and encouraged peer pressure within the team. We found that it's critical to have attentive management and quality assurance people available, continuously reviewing data—and staff hours—on a weekly basis to ensure that requirements and projections are met.*

If your County is already contracting with your organization using general fund dollars to pay for reimbursable mental health services, it is in their interest to work in partnership with your organization to maximize Medi-Cal funding. Therefore, County staff may be available to provide ongoing standards review, training, and support.

### **REIMBURSEMENT: How does Rehabilitative Mental Health funding work?**

Reimbursement rates for mental health services are set by the Medi-Cal State Plan. Rates vary for different services; for example the rate for medication management differs from the rate for crisis intervention and the rates (maximum allowable) change annually. Individual counties determine how much of their reimbursement gets passed on to their contracting organizations. When negotiating contracts with your County, it is helpful to know what the state rates are so that you know what the County will be reimbursed for services. Also, because of the match requirement, rate changes must be anticipated when negotiating contracts.

Once you have developed a profile of your mental health service users, to project service units and potential revenue, it is useful to overlay actual service need (typically a mix of frequent and low users) with available, eligible staff hours. Organizations contract with their County for an aggregate number of service units. Because services are paid at different rates, a mix of service units is desirable.

In housing and voluntary service models, the use of services tends to vary a great deal from month to month and season to season. This inherent variation can make it difficult to predict billable hours and project units of service and revenue. Early on in their tenancy, for example, tenants may use services intensively. Then, as they stabilize, they use the same services more moderately. Economies of scale can help to mitigate this factor of unpredictability. A multi-housing-site organization that is certified across sites can spread the risk by projecting aggregate hours, with billable service hours being greater in some buildings some months and lower in others, but balancing out across projects. In contrast, if you operate services in a single project, you have far less opportunity to spread the risk.

An experienced director notes:

*From experience, we advise that you initially aim low and see how it evolves. In fact ideally we recommend that you pilot this Medi-Cal model for a year—changing the culture and protocol within your organization—while still receiving grant funding. That way, you can build trust in—and capacity within—your service model, ensure that you have the right staff in place, and build documentation practices before relying on Medi-Cal as a revenue stream.*

### **PARTNERSHIP: What kind of partnership does Rehabilitative Mental Health require?**

In California, all reimbursement for Specialty Mental Health Services is administered through County departments, and therefore each County is responsible for paying their nonfederal (state) share of Medi-Cal costs and for obtaining FMAP through the state. Given this, a contract with your County is a prerequisite to qualifying for this reimbursement.

Most supportive housing providers using this reimbursement option to date have had pre-existing County contracts with their County to provide mental health services. If you decide to pursue a contract for the first time, be prepared to demonstrate to the County that you provide, or intend to provide, housing and mental health services to Medi-Cal eligible tenants who fall within their target population as defined by the Mental Health Plan. If you are serving the County's target population, it is certainly in their interest to explore stable housing with ongoing services for this population, thereby reducing their dependence on locally funded high-end systems of care.

**CASE STUDY:** In one California County, a Housing Authority/ Mental Health partnership commented:

*The idea of this collaboration came from the Housing Authority. They came to the Mental Health Department and said, "We are working with tenants who are your clients and they are losing their housing. A supportive housing model, with on-site support services, can help us both to better serve your clients."*

### **RESOURCES: Where can you read more about Rehabilitative Mental Health?**

Overview, Corporation for Supportive Housing white paper:

<http://documents.csh.org/documents/policy/Med/MedicaidOpportunities.doc>

California Department of Mental Health:

<http://www.dmh.cahwnet.gov/>

Medi-Cal Specialty Mental Health Managed Care Program:  
<http://www.dmh.cahwnet.gov/SpecialPrograms/medi-cal.asp>

Definition of the Rehabilitative Mental Health option:  
<http://www.dmh.cahwnet.gov/SpecialPrograms/docs/medicare-faq.pdf>

# FEDERALLY QUALIFIED HEALTH CENTER (FQHC)

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## **OVERVIEW: What is a Federally Qualified Health Center (FQHC)?**

FQHCs are non-profit consumer-directed health organizations that provide high quality health care to the under-served and the uninsured in urban or rural areas defined as “medically under-served areas.” This category includes, among others, Community Health Centers, Migrant Health Centers, and Health Care for the Homeless Programs. FQHCs provide health care to very low-income or homeless people who are likely to need comprehensive and expensive primary care—precisely those likely to be living in supportive housing. Federal funding is available to reimburse registered FQHCs for face-to-face professional services, including mental health services, provided to Medicare and Medicaid-insured individuals. In general this reimbursement rate is higher than other Medi-Cal funding streams in recognition of the likelihood that clients accessing FQHCs are likely to need more comprehensive and costly care than those accessing other health care settings. Like supportive housing, this model of care is intended to help control costs associated with chronic disease and to decrease dependence on the use of high-end systems of care such as emergency rooms and hospitalization.

An organization that is already a health care provider to this population can explore certification as an FQHC, noting that this is a time- and resource-consuming process. For supportive housing providers serving tenants with complex medical and behavioral health issues, formal partnership with a local FQHC may be a practical option to provide and fund a broad array of health services to tenants.

Formal partnership with an FQHC entity can ensure medical services for tenants and access to a funding stream to (partially) pay for these services. In addition to obtaining Medi-Cal reimbursement, FQHCs may (competitively) access federal grant funding awarded directly to health centers to more fully cover the costs of delivering services to their clients—including those not eligible for Medicare. The value of FQHCs for supportive housing lies in guaranteeing service rather than in providing direct funds to the supportive housing project sponsor.

To qualify for FQHC Medi-Cal reimbursement, services must take the form of well documented, face-to-face interactions between clients and licensed practitioners.

***CHECKLIST: Can you access FQHC funding to fund services in supportive housing?***

<p>1. Do you currently provide primary health care services to a federally designated under-served population? i.e. are your clients registered Medicare beneficiaries or Medi-Cal eligible? Do they have chronic health issues and are they likely to need ongoing comprehensive primary care?</p>	<p>This is the core requirement for becoming an FQHC, but each program category has specific requirements. You may be eligible to apply for FQHC status, noting that this takes a great deal of work and two to five years.</p>
<p>2. Do your tenants have complex medical and behavioral health issues and are they likely to need ongoing comprehensive primary care?</p>	<p>FQHCs provide healthcare to homeless and very low-income people who are likely to need comprehensive and expensive primary care.</p>
<p>3. Do you work in partnership or collaboration with an FQHC in your area? Could you identify a suitable FQHC to work with?</p>	<p>Partnership is an effective way for supportive housing projects to ensure (partially) funded health services for their tenants. To identify appropriate FQHCs in your area, use this search engine: <a href="http://ask.hrsa.gov/pc/">http://ask.hrsa.gov/pc/</a></p>
<p>4. Do health services provided to tenants take the form of face-to-face interactions with licensed practitioners such as physicians, psychiatrists, clinical psychologists or licensed clinical social workers; or mid-level practitioners such as nurse practitioners?</p>	<p>FQHC funding reimburses face-to-face encounters between clients and these categories of practitioner.</p>
<p>5. Does your documentation meet the requirements for FQHC funding?</p>	<p>For FQHC reimbursement, medical necessity must be documented, and each billed service must have a corresponding clinical note with assessment, diagnosis, and treatment plan.</p>

## **SERVICES: What do FQHC funds cover?**

FQHCs receive cost-based reimbursements for health care services in the form of face-to-face encounters only. Reimbursement not only covers primary care and health education but can also cover conditions that are addressed in a primary care setting such as substance abuse, depression, and chronic pain. Eligible reimbursements for health care services through an FQHC are much more flexible than those under Mental Health streams. As an example of flexibility, treatment for grief and anxiety can be reimbursed when provided through an FQHC.

FQHCs may bill for services from (among others) a physician, physician assistant, nurse practitioner, licensed clinical social worker, and clinical psychologist, as well as “incident to” physician’s services such as lab and x-ray services.

## **POPULATIONS: Who is served by FQHCs?**

FQHCs provide health care to very low-income or homeless people who are likely to need comprehensive and expensive primary care. FQHCs must provide services to patients regardless of insurance status, although they receive Medi-Cal reimbursement only for eligible services provided to Medicaid (and/or Medicare) insured clients. Additional federal grant funding (Department of Health and Human Services Bureau of Primary Health Care) may be used for services to patients who are uninsured, and for other costs not covered by Medicare or Medicaid reimbursement. Because FQHCs are reimbursed at higher rates for their services, many find it possible to use their other grant funds to provide care for uninsured clients. Also, the higher rate factors in non-licensed staff costs.

## **PROVIDERS: Who may provide FQHC-reimbursable services?**

Only a select number of licensed professionals are considered billable providers under FQHC provisions that govern Medi-Cal reimbursement. These include licensed practitioners: physicians, psychiatrists, clinical psychologists, and clinical social workers. Mid-level practitioners, such as nurse practitioners and physicians' assistants, may also be recognized. An intern may only bill for services if the licensed professional supervising her/him also sees the client for a face-to-face visit.

## **REQUIREMENTS: What are FQHC’s requirements for service reimbursement?**

Requirements for becoming an FQHC are fairly stringent and the process can take up to five years, so providers are not advised to seek this classification solely in order to access service reimbursement. Each FQHC program—such as Community Health

Centers and Health Care for the Homeless—has its own set of registration eligibility criteria. The core requirement for any FQHC, however, is to provide primary health care services to a federally designated under-served population. Most programs must also feature a significant level of community participation. For example, 50% + 1 board members must be users of the program's services.

Once you have FQHC status or a partnership with an FQHC, service reimbursement requires documentation to indicate medical necessity and each billed service must have a corresponding clinical note with an assessment, diagnosis, and treatment plan. While services in and of themselves may qualify for FQHC funds, reimbursement depends on accurate billing and documentation. Training on the importance of billing is recommended for all managers who need to understand the particular and detailed procedures involved.

### **REIMBURSEMENT: How does FQHC billing work?**

An FQHC is itself the entity which receives Medicare and Medicaid reimbursement (unlike TCM or the mental health rehab option, where funds are paid to the County), so negotiations and partnership with local authorities are not necessary. Instead, reimbursement comes from:

- Medicare FQHC trust funds via a fiscal intermediary,
- or from half state/half federal Medicaid moneys paid by the state via an intermediary,
- or both.

Payment is based on submission of claims (rather than being tallied annually as with TCM reimbursement). Response is fast on a clean claim—one with all the necessary paperwork and straightforward eligibility. However, there can be delays due to denials, complicated reconciliations, and dual eligibility (both Medicaid and Medicare).

FQHC dollars come as reimbursement, not a grant, so for budgeting purposes agencies must predict in advance the number of billable units of face-to-face service provision.

Rates are calculated according to costs at that particular FQHC. As an example, the FQHC in the case study below quotes these rates:

- Under Medicare, 80% of the capped urban rate (approximately \$106) per visit.
- Under Medi-Cal, visit rate per site averaging about \$150.

**CASE STUDIES:** An FQHC is the lead in a service collaborative that provides support services to tenants living in eight supportive housing sites throughout the County. The majority of tenants were formerly homeless and have chronic health conditions. Nurse

practitioners and physicians set up regularly scheduled mini-clinics in each of the eight supportive housing sites to provide primary care and licensed social workers make home visits. In mid-2004, the project's director estimated that:

*FQHC reimbursement covers between 20 and 25% of our program expenses at this time. Our higher reimbursement rate is supposed to help us cover the cost of providing care to the uninsured and for non-licensed professional costs but it does not cover all of the costs in the supportive housing program. Therefore, right now we rely heavily on public and private grants and fundraising.*

*While the current model of mobile services provides low-threshold access for tenants, it does result in inefficiencies, reflected in unbillable hours, which must be compensated for with grant funding.*

*Multi-site, multi-staff accountability is difficult. Right now, staff have a lot of downtime. Sometimes they set up their mobile clinic and tenants don't show up. The staff must be paid, but there is no reimbursement for their time. Group visits are seriously under-billed. Theoretically, licensed staff should have seven billable hours a day but our staff have a lot of down time due to no shows. We do currently have performance goals, which are two visits per hour, but lack of supervision and the mobile model means that few people are meeting these goals.*

*We are currently looking into moving away from the mobile service model and towards a central clinic model in order to utilize staff time more efficiently. Tenants from supportive housing sites throughout the County could go to this clinic. A clinic model would make it easier to meet our goals. We could, for example, double-book appointments, particularly with those clients that tend to be no-shows. A central clinic could also help us to avoid the home-visit stigma concerns. This shift, along with hiring a licensed person to be a service coordinator, could make it more realistic for staff to meet their billable service goals. They would have more focused and scheduled time. If that happened we could probably double our insurance revenue.*

*While this change makes sense fiscally, there are some trade-offs that are particular to supportive housing. A clinic model could result in the loss of opportunity to engage with tenants informally. It would also raise some challenges for service team and property management coordination.*

In another example, an FQHC provides health services to tenants in six buildings. This FQHC combines both a clinic and a mobile model. Each staff person works 50% time in the clinic and 50% time on the roving team, which allows for opportunity to develop relationships and build trust, increasing the likelihood that patients will come into the clinic. Using this County’s flat reimbursement rate of \$209 per encounter, potential revenue is illustrated in the following two examples:

EXAMPLE A	<i>100 unit building with some on-site services</i>	<i>10 Medi-Cal patients seen weekly</i>	<i>10 x \$209 = \$2090/week x 52 weeks/year = \$108,680/year</i>
EXAMPLE B	<i>100 unit building with extensive services</i>	<i>20 Medi-Cal patients seen 3 times per week</i>	<i>20 x \$209 = \$4,180/day x 3 times/week x 52/weeks = \$652,080/year</i>

**PARTNERSHIP: How should you approach an FQHC?**

Assuming that your agency is not itself an FQHC and that your tenant population requires ongoing primary and behavioral health care services, collaboration with an FQHC could be mutually beneficial and a promising strategy for sustaining these services.

An experienced administrator in the field suggests this strategy:

*If you are doing supportive housing for a tenant population with ongoing health issues, explore partnering with an existing FQHC. Ask them: "Can we find a way to expand your services, serve our tenants, and get your staff to be more mobile?" For instance, make a connection with Health Care for the Homeless in your community. They want to find housing for their clients and you have housing but want to secure services. Negotiate a relationship with them that ensures these services for your tenants.*

**RESOURCES: Where can you read more about FQHCs?**

Overview, Corporation for Supportive Housing white paper:

<http://documents.csh.org/documents/policy/Med/MedicaidOpportunities.doc>

General information including a reimbursement manual:

<http://www.cms.hhs.gov/providers/fqhc/#res>

Legislation (Consolidation of Health Centers Act):

<http://bphc.hrsa.gov/Grants/Health%20Centers%20Consolidation%20Act.pdf>

Find FQHC and similar sites in your area:

<http://ask.hrsa.gov/pc/>

Specifics about FQHC and other Medicaid services in California:

<http://www.hrsa.gov/tpr/states/California-Medicaid-Covered-Services.htm>