Introduction

The Patient Protection and Affordable Care Act of 2010 (the ACA) aims to increase access to care, improve the quality of care, and lower total health care costs. While the ACA can benefit all individuals and families, it has significant potential in expanding and improving services for those experiencing homelessness. Through the optional expansion of Medicaid and adoption of Medicaid waiver services and state plan amendments (SPAs), the ACA adds flexibility to the health care system to better meet the needs of low-income populations.

The mission of this paper is threefold. First, it provides detailed information about a selection of Medicaid and non-Medicaid provisions that states can implement to increase access to services and to expand the types of services available to people experiencing homelessness. This includes components established by the ACA as well as pre-existing opportunities. Second, it presents examples of how some states have taken advantage of these opportunities. And finally, it provides homeless service agencies with guidance on how best to advocate for change in their state’s health care system to better meet the needs of their clients.

Impact of the Affordable Care Act: A Quick Overview

Under the ACA, there is significant potential to improve and expand access to quality services for people experiencing homelessness and those at risk of becoming homeless. Taking a “whole person” approach to health care delivery, the ACA supports integrated services, coordination across providers, comprehensive preventive care, behavioral health care, health education (including substance abuse education), and evaluation activities (USICH, n.d. a). States have considerable discretion about how to implement health care provisions under the ACA. The following are examples of specific service expansion and funding opportunities for homeless service providers:

- States have the option to expand Medicaid to cover anyone whose income is at or below 133% of the federal poverty line, including millions of homeless adults. As of this writing, twenty-six states and the District of Columbia have exercised this option (Center on Budget and Policy Priorities, 2013).

- Home and Community-Based Services (HCBS) Medicaid waivers and state plan amendments (SPAs) now cover a wider range of services than previously, and are easier for states to adopt—particularly the 1915(i) SPA and the 1915(c) waiver options (NAEH, 2013).

- States can create “health homes” to cover a spectrum of care management and coordination services for people with chronic health issues and/or mental illness—conditions that are highly common among people who are homeless. This option is authorized by a new state Medicaid plan provision (CSH, 2011; Nardone et al., 2012; Mechanic, 2012; NAEH, 2013).

- Federal and state agencies can evaluate innovative approaches to health care delivery and cost savings, largely through a “demonstration
There are multiple Medicaid waivers and funding opportunities that can be used by states to expand services to people experiencing homelessness. Table 1 presents the eligibility requirements and potential services covered by each of these. The following sections provide more detailed information, and expand on how each type of opportunity may benefit homeless service providers and their clients.

Opportunities to Expand Medicaid Services

There are multiple waivers that states can adopt, as well as state plan amendments (SPAs) that states may propose to the Centers for Medicare and Medicaid Services (CMS), to expand services covered through Medicaid. A waiver is an exception to some restrictions on what services can be reimbursed through Medicaid. An SPA is simply a proposed set of changes. Different types of waivers and SPAs entail different federal-state reimbursement ratios, and some are easier for states to obtain than others. For example, a 1915(i) SPA may be relatively straightforward to obtain, and the federal government will reimburse 50% or more (depending on the state) of the costs for specified services to target-ed populations under this SPA. Health homes are a different type of SPA, under which the federal government will reimburse 90% of costs for services for the first two years of implementation, after which the match rate will adjust to the ratio for reimbursing standard Medicaid services in that particular state.

The process of proposing health home amendments to a state Medicaid plan and getting these amendments approved by CMS is more rigorous and complex than applying for the 1915(i) SPA.

### 1915 Home and Community-Based Services (HCBS) waivers and SPAs

HCBS-1915(i) existed prior to the ACA. However, the ACA made them easier for states to use, and created a couple of new types. The two main types that pertain to services for people who are homeless—1915(c) waivers and 1915(i) SPAs—predate the ACA.

The 1915(i) SPA, originally established with the Deficit Reduction Act of 2005, is a permanent amendment to support individuals who can live in the community but need a range of services to do so. This SPA can be used to target populations with specifically defined health conditions. Once approved, the SPA provides a 50/50 federal-state reimbursement rate (or higher, depending on the state) to fund case management, personal care, adult day health, and home health aide services. For individuals with mental illness, it also covers psychosocial rehabilitation services. (Mann, 2010a; NHCHC, 2012; CSH, 2010; Nardone et al., 2012).

Because there is significant overlap between those who would benefit from supportive housing and those who would qualify for services under this SPA, it could be used to provide care to some of the most vulnerable tenants in supportive housing. Further, many of the services covered under this SPA are the same as those commonly provided by supportive housing programs.

<table>
<thead>
<tr>
<th>What is it called?</th>
<th>Did it exist pre-ACA?</th>
<th>Who qualifies?</th>
<th>What services are covered? *</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCBS-1915(i)</td>
<td>Yes</td>
<td>Individuals who can live in the community but need a range of services to do so.</td>
<td>Case management, personal care, adult day health, home health aide, and psychosocial rehabilitation.</td>
</tr>
<tr>
<td>HCBS-1915(c)</td>
<td>Yes</td>
<td>Individuals whose disability level meets eligibility for institutional care.</td>
<td>Case management, home health aide, personal care, adult day health, and respite care.</td>
</tr>
<tr>
<td>Community 1st Choice-1915(k)</td>
<td>No</td>
<td>Individuals who would otherwise need institutional care.</td>
<td>Home attendance assistance with daily living and health related tasks.</td>
</tr>
<tr>
<td>Health Homes</td>
<td>No</td>
<td>Individuals with chronic health conditions or serious mental illness.</td>
<td>Care management and coordination, transitional and follow-up care, referrals.</td>
</tr>
<tr>
<td>Rehabilitation Option</td>
<td>Yes</td>
<td>Individuals who need to attain/retain independence or self-care abilities.</td>
<td>Medical and remedial rehabilitation services, including diagnosis and screening.</td>
</tr>
<tr>
<td>1115 Waiver</td>
<td>Yes</td>
<td>Proposed by state.</td>
<td>Proposed by state.</td>
</tr>
<tr>
<td>CMS Center for Innovations RFPs</td>
<td>No</td>
<td>Proposed by state.</td>
<td>Proposed by state.</td>
</tr>
</tbody>
</table>

* Note: Services listed are examples, and not a complete list of all possible services covered.
The ACA also eliminated waiting lists to be eligible for services under this SPA (CSH, 2010). Though not specifically pertinent to the homeless population, this waiver option could apply to a nursing facility. The ACA also eliminated waiting lists to be eligible for services under this SPA (CSH, 2010). By removing the cap on the number of individuals who can be enrolled, the ACA also eliminated waiting lists to be eligible for services under this SPA (CSH, 2010).

The 1915(c) waiver is similar to the 1915(i) SPA in that it provides case management, psychosocial rehabilitation, and other services for individuals with serious mental illness or other disabling conditions. However, this waiver applies exclusively to individuals who meet a state’s eligibility requirements for institutional care (due to mental disabilities, physical disabilities, developmental disabilities, old age, etc.). By contrast, the 1915(i) SPA applies to a wider range of persons with physical and behavioral health issues, many of whom can maintain (with support) a measure of independence in their communities (NHCHC, 2012). As the target population of a 1915(i) SPA need not require institutional care, for practical purposes this SPA essentially broadens the scope of the 1915(c) waiver.

Since homeless service agencies are positioned to ensure that HCBS-eligible homeless individuals are getting their health care needs met, homeless service agencies can apply to become HCBS providers. Another option is to team up with an existing HCBS provider, coordinating services and providing education about the particular needs of the homeless population (NHCHC, 2012).

The 1915(k) waiver option, established by the ACA, is also known as the Community First Choice Option. It provides for daily living assistance services to persons who would otherwise need to be housed in a skilled nursing facility. Though not specifically pertinent to the homeless population, this waiver option could apply to supportive housing residents with severe mental illness and substance abuse issues, or other severely disabling conditions. Under this waiver, when an individual is moved from an institution into a community, states may contribute to such expenses as security and utility deposits, first month’s rent, and basic household supplies (NHCHC, 2012; Mechanic, 2012).

The Medicaid rehabilitation option, which predates the ACA, covers services that are specifically rehabilitative—that is, they must help a person to regain functions that have been lost in some way. In some states, therapy, counseling, and other mental health services may be reimbursable under this waiver.

These various waivers and SPAs have already been put to tremendous use. For example, utilizing the 1915(c) waiver and 1915(i) SPA, Louisiana maintains a 3,000-unit permanent supportive housing program that includes case management, mental health and substance abuse treatment, developmental disabilities services, and care coordination. Similarly, Iowa operates a state-funded rental subsidy program that helps people obtain housing while also receiving a variety of services and benefits courtesy of (50% federally subsidized) HCBS Medicaid waivers and SPAs (NHCHC, 2012).

Opportunities for Demonstration Projects

1115 Demonstration Project Waivers

A different type of Medicaid waiver, the 1115 waiver, has the potential for very broad application. Established by the Social Security Act, this waiver allows states to apply to expand eligibility, restructure funding or payment processes, or use Medicaid to fund nearly any type of conceivable service, so long as they can illustrate a medical necessity and demonstrate—or make a convincing case—that the proposed changes will have a budget-neutral effect. Once approved by CMS and the Secretary of Health and Human Services, demonstration projects under this waiver remain in effect for five years, with the possibility of renewal (Kaiser, 2011).

The original Medicaid statute explicitly prohibits the use of Medicaid funds to pay for room and board. But efforts are under way to make a case that providing funding for housing assistance, for example, can reduce expenditures in other areas, such as emergency room usage (more on this below). Advocates argue that, in fact, Medicaid does pay for nursing home care, and in this way, it also does pay for room and board. According to Peggy Bailey of the Corporation for Supportive Housing, “Our first responsibility is to achieve coordinated and comprehensive reimbursement for the services component of supportive housing. However, using evaluative data, we are working to persuasively frame supportive housing as a specific (and less expensive) health intervention, so it makes sense for Medicaid to experiment with ways of assisting with the housing component as well.”

As yet, the above argument has not achieved a significant amount of traction with CMS. Nonetheless, the state of Rhode Island included a set of supportive housing service benefits in their 1115 waiver proposal.
Most of that proposal has been approved by CMS, though a decision on the sections pertaining to supportive housing is pending until Summer 2014.

**Illinois** recently submitted a 1115 waiver proposal that sets up health outcome and cost savings performance standards for the managed care organizations (MCOs) that administer Medicaid funds in that state. If the MCOs can meet these performance standards, they will receive incentive payments from the state through Medicaid. Illinois’ waiver proposal would allow the MCOs to use these incentive payments to pay for supportive housing services, including mental health services and rental assistance.

**CMS Innovation Center RFPs**

In a related vein, the ACA established the Center for Medicare and Medicaid Innovation, which periodically issues RFPs for demonstration projects—innovative health care delivery approaches that may achieve better health outcomes and cost efficiencies. The Center’s website states:

> The Health Care Innovation Awards are funding up to $1 billion in awards to organizations that are implementing the most compelling new ideas to deliver better health, improved care and lower costs to people enrolled in Medicare, Medicaid and Children’s Health Insurance Program (CHIP), particularly those with the highest health care needs (http://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/).

One such award was granted to the National Health Care for the Homeless Council to test the impact of community health workers in emergency rooms in ten cities for a period of three years. The purpose of the project was to determine whether the health workers’ presence – and their efforts to situate homeless individuals in a more stable continuum of care – could help to reduce the chronic use of emergency room services by people experiencing homelessness.

Thus far, the Center for Medicare and Medicaid Innovation has administered two rounds of healthcare innovation RFPs. A future third round is uncertain at the time of this writing. It is also important to note that federal funding for these demonstration projects expires after a two-to-three-year period, after which much will depend on available funding and the performance of previously-funded projects.

In the meantime, there exist ongoing “dual demonstration” programs that provide services benefitting individuals eligible for both Medicare and Medicaid. Housing service providers might learn about such programs in their vicinity, contact the entity or entities spearheading the project, and find out if the housing service provider’s interventions can be of benefit to members of the dual-eligible population served by the project.

**Collaborating with Other Organizations**

**Become Part of a Medicaid Health Home**

Established by the ACA, a health home is a coordinated team of health care providers or agencies (or, more rarely, a single agency) that provides a comprehensive system of care coordination for individuals with chronic health conditions. The goal of the health home is to integrate and coordinate primary, acute, behavioral health, and long term services and supports for a specifically defined population that either:

- has one chronic health condition (such as heart disease or diabetes), and is at risk for another;
- has two or more chronic health conditions; or
- suffers from mental illness (CMS, 2012; Mann, 2010b).

The concept behind health homes is that, for targeted populations, different providers will share data across a coordinated network, thereby gaining access to a complete picture of each individual’s health care needs and history. By definition, as per a 2010 letter issued to State Medicaid Directors (Mann, 2010b) by the Centers for Medicare and Medicaid Services (CMS), a health home must provide:

- Comprehensive care management and care coordination;
- Health promotion;
- Individual and family support;
- Transitional and follow-up care (i.e. from inpatient settings);
- Referrals to community and social support services; and
- Linkage of different services through health information technology.

To create a health home(s), a state must apply to CMS for permission to include this option within its state Medicaid plan. The state defines the desired target population, what services the health home will provide, and how it will operate (Mann, 2010b; CSH, 2011). After getting a health home amendment approved by CMS, the state initiates an RFP process. The RFP stipulates what type of agency can lead a health home, what services must be included, what types of partners are necessary, target population(s), reimbursement mechanisms, and so on. Provider networks in the state organize themselves and apply, as a unit,
to be a health home. A single provider or agency is not likely to be able to provide all of the services required to comprise a health home network, though this occasionally happens. Once approved, for the first two years of a health home’s existence, the federal Medicaid match rate for services provided by the health home is 90 percent, after which the rate equals that for standard Medicaid services in a given state (Mann, 2010b).

Providers within the health home share patient data. One agency or provider is designated the “lead entity” for a given health home. A “care coordinator” refers people to appropriate providers within the system and follows up with patients regarding what services they are accessing. A state Medicaid plan may contain multiple health home provisions that target different populations (Mann, 2010b). For example, one health home amendment can focus on people with mental health issues, and another on people with HIV and diabetes. Additionally, a health home can be used to expand the capabilities of a state’s existing patient-centered medical homes, by fostering linkages to community and social supports, and enhancing the coordination and integration of primary and behavioral health care (Mann, 2010b).

States have enormous flexibility in how they set up their health homes (NAEH, 2013; Mann, 2010b). There is tremendous overlap between the needs of people experiencing homelessness and targeted health home populations, as a large number of homeless individuals suffer from mental illness, substance abuse disorders, and/or other chronic health conditions, and need the services provided by health homes, such as care management and coordination. In fact, the health home model has a great deal in common with the services normally included in supportive housing (CSH, 2011).

As noted above, one of the categories of services that a health home is required to provide is “referrals to community and social support services.” Depending on how this requirement is construed in a given plan, it can include referrals to supportive housing and other services for a homeless population.

States can decide to include housing-related services as a mandatory feature of their health home networks. However, New York, thus far, is the only state that requires supportive housing as one element of a health home. Therefore, if a hospital system wants to create a health home network in New York state, they will need to include supportive housing providers in their network, because they will have to refer their indigent clients to those providers. In Washington state, housing providers are included as potential partners in health homes, though not mandated as such.

Though it is unlikely that a housing provider could be designated as a lead entity for a health home, homeless service agency directors can look to affiliate with health home networks. Depending on the target population of a health home, a homeless services agency director might approach the lead agency or care coordinator and say, “Have you noticed that some of your clients need housing, and that you have not been able to control costs for these clients? If you pay us to provide case management services, we can help you contain those costs and serve these individuals.” In some cases too, the homeless services agency might be included as a partner at the inception of a given health home.

Affiliating with Managed Care Organizations

Many states will contract (or have contracted) with large managed care organizations (MCOs), which administer services to the state’s Medicaid enrollees. Therefore, another strategy that homeless services agencies, working within their continuum of care, may adopt is to approach MCOs and make the case that the provision of certain essential—and, in many cases, nonclinical—services, such as case management, care coordination, or conceivably even rental assistance, can ultimately benefit the MCO’s balance sheet. MCOs may be approached directly, through your continuum of care’s health service provider, or through other intermediary agencies. As Barbara DiPietro, the Director of Policy for the National Healthcare for the Homeless Council, points out:

The MCOs are a step closer to your population than the state Medicaid office, and they are going to be interested in bringing costs down. If there’s a guy costing them $80,000 a month in multiple ER visits and surgeries, and if a thousand bucks a month in rental assistance could bring his monthly Medicaid utilization down by five thousand—hey, they’re business people. And unlike government departments, MCOs have a lot of flexibility in doing whatever they deem practical to improve their bottom line (personal communication, 2/18/14).

In short, insurance companies may find it valuable to invest in services that address the roots of health risk behaviors, thereby averting more serious health problems that entail a higher financial cost. In making this case to an MCO, it is helpful to bring statistical evidence that shows cost reductions are a likely outcome of supportive services. The Corporation for Supportive Housing (for example) has done a number of studies that bear this out.
Working with Federally Qualified Health Centers

With a focus on providing comprehensive health care to underserved communities, Federally Qualified Health Centers (FQHCs) are commonly community health centers, public housing programs, tribal health programs providing outpatient services, Health Care for the Homeless programs, and other programs serving migrant or homeless populations. FQHCs are required to provide preventive health care, dental services, mental health and substance abuse services, transportation services for health care, and hospital and specialty care, either on-site or in collaboration with other providers (Rural Assistance Center, 2013).

FQHCs can receive services reimbursement under both Medicare and Medicaid, and they receive an elevated Medicaid reimbursement rate for a variety of services, including case management and psychosocial support services (Rural Assistance Center, 2013). Obtaining FQHC designation for your agency or—more simply—partnering with an organization or agency that is already an FQHC, such as a multiservice clinical health center, is a critical funding opportunity for homeless service agencies (USICH, n.d. b).

Denver’s Colorado Coalition for the Homeless, which serves over 16,000 clients each year, became an FQHC, and was able to expand its primary and mental health services (originally only offered through a clinic) into supportive housing developments and scatter-site units. John Parvensky, the agency’s CEO, states:

*Medicaid is critical to our funding for integrated primary health care, mental health care, and substance abuse treatment services for homeless individuals and families... The ability to receive cost-based reimbursement through the Federally Qualified Health Center (FQHC) designation is vital... Our greatest success has been creating teams of clinical case managers (LCSWs) who are eligible to bill for Medicaid services provided to residents in supportive housing and non-clinical case managers who work together to serve chronically homeless individuals. Agencies need to become FQHC qualified, or team up with FQHC providers, to develop a service plan for supportive housing residents and a reimbursement plan to sustain it (USICH, n.d. b).*

Collaborative relationships with FQHC-designated agencies or organizations that serve populations with similar issues to your agency’s clients (e.g. mental health issues, substance abuse, and addiction issues) are strongly recommended. For example, in some cases, an FQHC-designated health center may be willing to site clinical and/or nonclinical staff at a non-FQHC-designated homeless services agency. Such partnerships can be mutually beneficial, because the result may be that the agency’s homeless clients will make less frequent use of the more expensive clinical and emergency services provided at the health center.

FQHC-designated agency staff may also provide on-site clinics and home visits to clients who live in supportive housing. On-site or in-home services may include (but are not limited to) case management, health education, mental health counseling, and psychiatry (Rural Assistance Center, 2013; USICH, n.d. b).

Evidence of Cost Savings and Effectiveness

Multiple studies have illustrated that supportive housing-related services are both cost-efficient to Medicaid and effective in facilitating better health outcomes. Here is a sampling of the evidence at hand:

- The Chicago Housing for Health Partnership provided housing and case management services to approximately 200 homeless individuals. Over the course of 18 months, in contrast to a control group who were not provided services, these individuals used the hospital emergency department 24% less often and had 29% fewer hospital admissions, thus saving nearly $25,000 per person per year in Medicaid costs (Ladowski et al., 2009).

- Similarly, the California Frequent Users of Health Systems Initiative saw a 27% reduction in hospital admissions and inpatient days for homeless clients who received case management and access to housing. On average, before being housed, these individuals cost Medicaid approximately $58,000 per person per year in hospital emergency and inpatient services. After being housed, this figure dropped to about $19,000 per person per year (Linkins et al., 2008).

- In Washington, the Seattle East Lake project found that after a year of supportive housing, formerly homeless residents accounted for 41% less Medicaid expenses, due to reduced emergency room visits and hospital stays. Also, supportive housing tenants reduced their alcohol usage by 30% (Larimer et al., 2009).

- Studies in Massachusetts, California, and New York showed that homeless individuals accounted for an extremely high proportion of hospital admissions and emergency services. In MA, the Boston Health Care for the Homeless program tracked 119 homeless adults for five years and...
found that, collectively, these individuals used the hospital emergency department 18,384 times and were hospitalized 871 times. The average annual health care cost per individual was $24,486 (MHSA, 2007). In CA, the Frequent Users of Health Systems Initiative found that approximately 45% of chronic emergency department users were homeless. In NY, a study of frequent hospital service users found that 60% were either homeless or at risk of homelessness (Linkins et al., 2008).

- A study in Denver, CO found that 43% of supportive housing residents experienced improved mental health outcomes (Perlman & Parvensky, 2006).

- A San Francisco, CA study found people with HIV/AIDS had an 81% five-year survival rate in supportive housing, as compared to a 67% survival rate if not housed (Martinez & Burt, 2006). A Chicago study reached a similar result: a 55% survival rate for supportive housing tenants as compared to 35% for the unhoused (Ladowski et al., 2009).

### Affecting Health Care Opportunities in Your State

Learning what opportunities exist in your state is an important first step toward expanding and enhancing services for your clients. Further, developing relationships with other agencies in your state and community can increase your ability to effect change at the state level, and your ability to successfully affiliate with local MCOs and FQHCs will depend on these connections. Therefore, networking is key—who knows who, who you have a relationship with, who will listen to your ideas, and who can and will act on your proposals. Therefore, it is wise to cultivate cordial relationships with your state Medicaid office and Department of Human Services, as well as within your continuum of care and system of local health care providers. Below is some specific guidance.

### Medicaid In Your State

Medicaid coverage decisions and reimbursable services vary significantly by state, and it is important to know what components have been included in your state’s plan. Contact your state Medicaid office to learn which of the waivers and amendments discussed above are in effect in your state. In some states, benefits are more generous than in others. However, even in states not expanding Medicaid coverage or implementing the optional provisions described above, some individuals and families experiencing homelessness may still qualify for Medicaid.

If your state did expand Medicaid coverage to all those at or below 133% of the federal poverty line, a large number of your clients may now be eligible. Therefore, one of your first challenges is to efficiently get newly eligible clients enrolled. In most communities, local health centers or state health and human service agencies provide enrollment services. Learn which agencies these are. Some states may also offer financial assistance to support enrollment efforts. Your state Medicaid office representative can advise you on this as well (NHCHC, 2012).

There are a number of ways to learn more about what kinds of Medicaid waivers and amendments your state implements. The first step would be to check your state’s Medicaid website for information (often presented in the form of fact sheets and checklists) about services, eligibility requirements, and target populations. If possible, it may be more fruitful to meet in person with someone from your state’s Medicaid office to discuss the needs of the population that you serve, and how Home and Community-Based Services waivers and amendments can help (NHCHC, 2012).

If you believe your state’s homeless population would benefit from the inclusion of additional service waivers or amendments that are currently not part of your state’s Medicaid plan, you can advocate to your state’s Medicaid office on behalf of your clients. One effective way of doing this is to collaborate with other agencies in your continuum of care and identify gaps
in needed services in your locale. Then, as a coalition, you can ask someone from your state Medicaid office, Department of Human Services, or Department of Public Health to come and talk to you and your continuum partners about what resources might be available to fill those gaps. For example, at such a meeting, you can advocate that your state’s HCBS program be expanded to meet your population’s needs, possibly through a 1915(i) amendment. In making this case, you can present evidence that (for example) case management and supportive housing services not only improve health outcomes but also help to reduce overall Medicaid expenses. Further, CMS is available to consult with states as they develop proposed changes to their state plans, and to provide technical assistance to support implementation.

Another way for you to potentially have input into your state’s Medicaid plan is to be on the alert for, and to attend, stakeholder meetings that the ACA requires states to hold prior to the implementation of state plan amendments.

**Working with Integrators**

Many states may have agencies that specialize in understanding its health care service system and state-level opportunities. This type of agency is sometimes called an “integrator”. An integrator (Berwick et al., 2008) could be an individual, organization, or team of individuals that understands the ACA, and bridges Medicaid, Medicare, public health, and homeless services. Integrators serve a convening role, and work across sectors. They generally comprehend the ins and outs of the health care and insurance system, including Medicaid rules and guidelines, so that funds are maximized and services are most effective (Berwick et al., 2008; Burton et al., 2013).

Hearth Connection in Minneapolis is an example of an integrator organization. As Program Director Kelby Grovender explains:

*Hearth Connection is an intermediary organization. We get state and federal, philanthropic and Medica [a local MCO] dollars. We create regional projects to end long-term homelessness and we subcontract with local service providers to implement the model. We don’t provide any direct services ourselves. Our motto is: ‘We absorb the complexity so that we can simply end homelessness.’ We lobby at the state legislature for increased funding for homeless programs, we do the high-level sorts of stuff, and hopefully we simplify the process and funnel it down to the local service providers (personal communication, 2/14/14).*

Integrator organizations can be very helpful in navigating the system in a variety of ways. They can identify resources, interface with the state, help coordinate care, and facilitate connections between agencies and providers of various stripes (Berwick et al., 2008).

**Conclusion**

With the implementation of the ACA, new opportunities to expand homeless services have been created. Combined with opportunities that pre-date the ACA, we are in a new universe of possibility for homeless services. Though there are few well-worn paths as of yet, people are accomplishing remarkable things, and the new funding streams are substantial. With the expansion of Medicaid, more monies are available for clinical and non-clinical services that were previously subsidized locally, and the resultant savings can be repurposed in many instances for a variety of supportive services to the homeless population, strengthening the safety net, improving health outcomes, and promoting long-term stability.

**References**

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