

Florida Supportive Housing Resource Map to Services

Prepared by the Technical Assistance Collaborative (TAC) for the:
Florida Supportive Housing Coalition, Inc.

With funding by:

Florida Housing Finance Corporation
Florida Department of Community Affairs
Miami Coalition for the Homeless, Inc.
Advocacy Center for Persons with Disabilities
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With funding by:

FLORIDA HOUSING FINANCE CORPORATION



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ADVOCACY CENTER FOR PERSONS WITH DISABILITIES

Florida's Protection and Advocacy Programs for Persons with Disabilities



Washington Mutual

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Section One: Background

Focus of the Resource Mapping Efforts

The Florida Supportive Housing Coalition requested a review and analysis of state controlled supportive services funding with the goal of identifying those most relevant to an expansion of supportive housing. The overall purpose of this project was to identify the core services needed by various populations in supportive housing and “map” the services to the various federal and state funding streams.

TAC implemented a multi-step process for this review and analysis. The first step was to identify the populations that were most at risk of homelessness. For the purpose of this project, the Coalition identified the following populations:

- Adults with mental illness
- Adults with a substance disorder
- Individuals with a co-occurring mental health and substance disorder
- Young people ages 18 to 22 transitioning out of foster care placements
- Individuals with a developmental disability

Once these populations were identified, TAC worked with the coalition to develop a matrix of services and supports that are necessary to support these populations in supported housing. The matrix was developed from key documents including the inventory of services developed by the Coalition, applicable Florida human services provider manuals and other relevant state documents that describe these services. The Coalition selected three services for the analysis:

- ***Community supports***—this includes services that allow individuals to learn skills needed to effectively manage their households including: case management, personal care, budgeting, food preparation etc.
- ***Tenancy Supports***—this includes housing search activities, benefits acquisition (including Section 8 Housing Choice vouchers), landlord liaison, and assistance meeting the rights and obligations of successful tenancy.
- ***Employment supports***—these services include job training, job search, employment supports, attainment of employment, income and benefits and matching of employment opportunities and experiences to benefit preservation strategies.

TAC analyzed each of these core services. The analysis focused on several key components:

- Federal and state mainstream funding sources available for each core service
- Description of the core service included in each funding stream
- Description of key requirements for each of the federal and state funding streams for that service (eligibility requirements, provider requirements, etc.)
- Barriers and opportunities for accessing or enhancing funding for these services.

Based on this analysis, specific recommendations were developed for accessing or enhancing funding for these core services for an expansion of supportive housing, including strategies that could be implemented by the Florida Supportive Housing Coalition.

Populations

Florida's Office on Homelessness estimates that there were 72,600 homeless people on any given night in 2003¹. There are many causes for homelessness, and most were directly related to poverty and the lack of affordable housing. The causes for poverty include, but are not limited to, unemployment and underemployment, low state and federal benefits, lack of education and job skills, lack of job and life skills including money management, or an emergency financial crisis.

People with disabilities have high risk factors for homelessness. The combination of extreme poverty and other personal vulnerabilities—including a disability—is a high predictor of homelessness. Mental illness in particular is noted in the research as a characteristic that increases vulnerability to homelessness. The FY 2002 Annual Report on Homeless Coalitions in Florida identified various characteristics of individuals who are homeless.² For instance:

- 37 percent of individuals who are homeless had a substance abuse disorder
- 25.5 percent had a mental health disorder
- 19.6 percent had a physical and/or developmental disability or primary health care problem

This data is consistent with most national estimates of the number of individuals who are homeless and have a disability. For instance, the National Survey of Homeless Assistance Providers and Clients estimates that 25 percent of homeless people are receiving some type of government disability benefit.³

¹ Council on Homelessness, 2003 Report, Florida Department of Children and Families, p.1.

² Annual Report on Homeless Conditions in Florida Fiscal Year 2001-2002, Florida Department of Children and Families, Office of Homelessness, July, 2003.

³ Opening Doors, Permanent Supportive Housing, Technical Assistance Collaborative, January, 2003.

The report also indicated that approximately 3 percent of the homeless population had a co-occurring mental illness. This seems like a very small number given that the Florida Commission on Mental Health and Substance Abuse Services found that 65 percent of those with a substance abuse dependence had at least one mental disorder and 51 percent of those with a mental disorder had at least one substance abuse disorder.⁴

Thirty-five percent of people in Florida who are homeless are children under the age of 18.⁵ Homeless children require special efforts and resources to ensure their needs are met. Children and adolescents who run away or are homeless are more difficult to engage and maintain in services. For many youth transitioning out of the foster care system, these challenges become even more difficult. Many of these youths become homeless within 12 to 18 months after leaving foster care. For many youth transitioning from the foster care system, the consequences of being left to fend for themselves at the age of 18 are far more grave. Studies show that within two to four years of leaving foster care:

- Only half of these young adults had completed high school;
- Fewer than half were employed;
- One-fourth had been homeless for at least one night;
- Thirty (30) percent had not had access to needed health care;
- Sixty (60) percent of the young women had given birth;
- And, not surprisingly, less than one-fifth of these young people were completely self-sufficient.⁶

Furthermore, many of these youngsters experience depression, isolation and loneliness.

The benefits of supportive housing services for many of these populations have been well documented. Studies found that homeless people with disabilities who moved to permanent housing experience marked reductions in shelter use, hospitalizations, length of stay per hospitalization, and time incarcerated. For instance:

- A study in California found that in the first twelve months of a supportive housing placement, the same population reduced its use of hospital emergency room by 58 percent and its inpatient admissions by 57 percent.⁷
- A study by the Corporation for Supportive Housing (CSH) found that Medicaid expenditures for mental health and substance abuse services decreased six months after homeless people moved into permanent supportive housing.⁸

⁴ Policy Paper on Co-occurring Mental Health and Substance Abuse Disorders, Florida Department of Children and Families, March, 2003.

⁵ ibid 1)

⁶ A National Evaluation of Title IV-E Foster Care Independent Living Programs for Youth. Phase 2: Final Report. Rockville, MD: Westat, Inc., 1991.

⁷ The Problem: Long Term Homelessness in America, Fact Sheet, Corporation for Supportive Housing, 1999.

- An Abt Associates evaluation of the CSH Next Steps employment initiative concluded that supportive housing-based employment programs increased tenants' earnings and rate of employment while reducing their dependence on public assistance.⁹
- A study of 900 individuals that were mentally ill and homeless provided with supportive housing showed that 83 percent remained housed a year later and that participants showed a decrease in symptoms.¹⁰
- Another study of almost 5,000 homeless individuals with mental illness placed in supportive housing through the New York/New York program found that 80 percent remained housed a year later.¹¹
- Once people with historic substance abuse achieve sobriety, their living situation is often a factor in their ability to stay clean and sober. A one year follow-up of 200 people found that 90 percent of those living in supportive housing were sober.
- A recent survey of transitional living programs (TLP) found that 78 percent of young people participating in TLP programs were employed either part- or full-time; 74 percent of youth were discharged to stable housing at the completion of the program, and, six months after completing participation in the program, 78 percent remained free of all direct government aid.¹²
- Research tells us that the Independent Living Program's services can and do make a difference in the lives of young people. A 1990 study found that providing more comprehensive services, including teaching a combination of skills—money management, consumer and credit management, education and employment skills—helped youth to achieve better outcomes. Improvements in outcomes were seen in increased high school graduation rates, greater ability to maintain a job for at least a year, accessing appropriate health services, avoiding young parenthood and decreased dependence on public assistance programs.¹³

Supports and Services

Supportive services are the “supports” in permanent supportive housing. Without them, the housing is the same as any other subsidized housing. Supportive services vary depending on who lives in the housing. Most permanent supportive housing providers offer some type of case management and housing support, but may also offer more intensive services such as mental health services, substance abuse services,

⁸ *ibid* 6).

⁹ Next Steps: Job Initiative Cost Effective Analysis, Corporation for Supportive Housing; Long, D., Doyle, H., January 1999.

¹⁰ *ibid* 5).

¹¹ *ibid* 5).

¹² Psychiatric Services, Pathways to Housing: Supported Housing for Street Dwelling Homeless Individuals with Psychiatric Disabilities, Tsemberis, S., Eisenberg, R. April, 2000.

¹³ Family and Youth Services Bureau, Transitional Living Program for Older Homeless Youth, Runaway and Homeless Youth Program Funding Announcement, March 2003.

vocational/employment services, etc. These services may be offered on-site or off-site at a community-based agency.

In order for supportive housing to work successfully there must be three elements: housing production, rent subsidies, and services and supports. Services and supports must promote integration, independence and housing retention. For *individuals with a mental illness and for individuals with a substance abuse disorder*, services must promote recovery and rehabilitation. The services and supports must be based on a recovery model that encourages self-determination by individuals and their families.

Substance abuse providers have always adopted a recovery approach to the treatment of the addiction. The mental health consumer movement has adopted the recovery philosophy. A major tenet of The President's New Freedom Commission on Mental Health was that services and supports "focus on the consumer's ability to successfully cope with life challenges, on facilitating recovery and on building resilience, not just on managing symptoms." Recovery-oriented services and supports that are often needed by individuals with a mental illness or a substance abuse disorder include: case management, employment supports, medication, counseling and peer supports.

Substance abuse and mental health treatment providers well recognize that *individuals with co-occurring disorders* present complicated, chronic, interrelated conditions that often require solutions that are personalized to the specific set of symptoms, level of severity, and other psychosocial and environmental factors. Thus, treatment plans must be individualized to address each person's specific needs using staged interventions and motivational enhancement to support recovery. In many instances, individuals with co-occurring disorders can benefit from the same types of treatment as individuals with a mental illness or addictive disorder. The difference is that the service planning and treatment programs must be integrated across providers. Integrated treatment for many individuals includes both medications and psychosocial treatments. Similarly, the substance abuse treatment system divided its services into either "alcohol" or "drug" treatment. Today most substance abuse treatment programs address both alcohol and drug problems.

For *individuals with developmental disabilities* who live in supportive housing, an approach that allows individuals to "self-direct" their own service is paramount to their success. This approach was based on research demonstrating increases in satisfaction and decreases in cost when: (a) people directed their own services, and (b) control over the nature, extent, and duration of services was shifted from professional provider organizations to the individuals and/or their families. Services needed by these individuals include: in-home supports, personal care assistance, homemaker services, companion services, support coordination and supported employment.

There are various services and supports for *foster care youth ages 16 - 21* that are at risk of homelessness to allow them to make a successful transition to self-sufficient adulthood by giving them the tools they need to live independently. These services provide youth with a supervised place to live for up to 18 months, life skills training (such as how to

budget, balance a checkbook, find an apartment or apply for a job), vocational training, and other support services. The primary purpose of these supports is to allow youth to complete their education, learn practical skills and develop positive relationships with mentors and peers, while living in a safe and supported environment. In this way, the program helps young people to become healthy, productive, self-sufficient adults, avoiding the risks of continued homelessness, long-term dependency on government aid or social services, or involvement with the criminal justice system.

The bottom line is that supportive services play a vital role in diverting people from emergency rooms, crisis care settings, long-term psychiatric care, nursing facilities, and in some cases the juvenile justice and criminal justice systems.

Financing Supportive Services

Permanent supportive housing integrates housing and services for extremely low-income people with disabilities. Depending on the model, supportive housing may have two or three separate funding components. These components include: 1) Capital Funding; 2) Operating or Rental Subsidies; and 3) Supportive Services. As indicated in the Housing Inventory Section of this report, it may be necessary to aggregate multiple funding sources of capital funding and operating subsidy to develop the housing component of supportive housing. Rent subsidy is essential for tenant-based models.

Mainstream funding for supportive services is no different. There are dozens of federal and state programs that can be used to finance the services needed for individuals in supportive housing. The major federal funding streams include:

- Medicaid
- Mental Health Block Grant
- Projects for Assistance in Transition from Homelessness
- Substance Abuse Prevention and Treatment Block Grant
- Temporary Assistance for Needy Families (TANF)
- Veteran's Affairs
- Runaway and Homeless Youth Act
- Transitional Living Program for Homeless Youth
- Workforce Investment Act
- Welfare to Work
- Ticket to Work: Work Incentives Improvement Act (TWWIIA)

Each mainstream funding source has different “rules” and presents a challenge to providers who are trying to wrap services and supports around an individual in supportive housing. Some of these programs are entitlements—individuals who are eligible for the program and meet various requirements must be provided these services and supports. However, many of these funding streams are capped—states receive a specific amount of funds regardless of the number of individuals that need and use these services.

Using “mainstream” funds for purchasing services and supports for individuals who are homeless or at risk of being homeless and who have a disability requires sophisticated knowledge of the federal and state funding streams. Specific information is needed regarding the eligibility criteria for each program as well as the specific services that can be (and in some instances cannot be) purchased with these funds. In some instances, these funding streams may have specific rules regarding the scope, amount and duration of services. In addition, some funding streams establish specific requirements regarding the qualifications agencies must have to provide these services.

The following section provides a detailed review of the major federal and state funding streams that can be used to provide community, tenancy and employment supports for the populations identified for this study. When applicable, information was provided on each component of the program, including:

- General Description of Funding Stream
- Eligibility Criteria
- Federal and State Administering Agency
- Financing
- Covered Services:
 - ✓ Goals and Outcomes
 - ✓ Service Activities
 - ✓ Provider Qualifications
 - ✓ Service limitations

Table 1, on the following page, provides an overview of the mainstream funding sources for the community, tenancy and employment supports for the populations covered in this report.

TABLE 1

	Medicaid					Block Grants		Others							
	TCM	Rehab Option	DD Waivers	Managed Care	FACT	MH	SAPT	PATH	TANF	WTW	WIA	TWWIIA	VETS	TLP	ILP
Service Coordination	X	X	X	X	X	X	X	X	X						
Benefits Acquisition	X		X		X	X	X	X	X						
Personal Financing/Budgeting		X	X		X	X	X	X	X					X	X
Skill Building/Training		X	X	X	X	X	X	X	X					X	X
Supported Employment			X						X	X	X		X		
Job training			X		X				X	X	X		X		X
Employment Supports		X	X		X				X	X	X	X	X	X	X
Tenancy Supports	X	X	X		X	X	X		X					X	X
Housing Counseling	X		X		X	X			X						X

Section Two: Funding Streams and Supports

< *Medicaid* >

Description of Program

The Medicaid Program is the third largest source of health insurance in the United States. As the largest program in the federal “safety net” of public assistance programs, Medicaid provides essential medical and medically related services to the most vulnerable populations in society. Medicaid covered 1,986,652 individuals in Florida in FY 2003, or approximately 12.2 percent of the total state population. The Medicaid program covers low-income women, children, elders, and individuals with disabilities. In FY 2003 the total expenditures for the Florida Medicaid program were approximately \$9.9 billion.

The Medicaid program was enacted in the same legislation that created the Medicare program – the Social Security Amendments of 1965 (P.L. 89-97). Medicaid is established by Title XIX. Prior to the passage of this law, health care services for people who were indigent were provided primarily through a patchwork of programs sponsored by state and local governments, charities, and community hospitals.

Eligibility Criteria

In general, Medicaid eligibility is based on a combination of financial and categorical eligibility requirements. Medicaid is a means-tested program. Beneficiaries must be low-income and meet certain resource standards. Each state determines income thresholds and resource standards for their Medicaid program following federal guidelines. These thresholds and standards can vary by state and may differ for each Medicaid-eligible population group within a state (e.g., children, adults, elders, and individuals with disabilities).

Medicaid services in Florida are administered by the Agency for Health Care Administration. Medicaid eligibility in Florida is determined either by the Department of Children and Families (DCF) or the Social Security Administration.

DCF determines Medicaid eligibility for:

- 1) Low-income families with children—There are several programs designed to provide Medicaid to parents or specified relatives and children in low-income families. Specified relatives include grandparents, aunts, uncles, first cousins, and others who are within the fifth degree of relationship to the child.

- 2) Children only—Florida has several programs designed to provide Medicaid for children only. The income limits for most of these programs vary based on the age of the child. Only the income of the child and parent(s) is counted when determining the child’s eligibility.
- 3) Pregnant women—There are several programs designed to provide Medicaid for pregnant women. When determining eligibility for pregnant women, the unborn child is always counted when looking at the income limit for the family. Women that are found eligible for Medicaid remain eligible throughout the pregnancy and for the two months following the birth of the child, as long as the mother remains a resident of Florida.
- 4) Non-citizens with medical emergencies—Non-citizens that would be Medicaid eligible on all factors other than their citizenship status may be eligible for Medicaid to cover medical emergencies, including the birth of a child.
- 5) Elderly and/or disabled individuals not currently receiving Supplemental Security Income (SSI)—The state has several programs designed to provide Medicaid to low-income individuals who are either elderly (65 or older) or have a disability. This is referred to as SSI Related Medicaid. Elderly or disabled individuals with children may be eligible for Medicaid if they are eligible for Section 1931 Medicaid. The Social Security Administration determines eligibility for the Supplemental Security Income (SSI) program.

Administrative Agency

Federal Medicaid regulations require each state to designate a “single state agency” responsible for the Medicaid program. The single state agency is designated to administer or supervise the administration of the State Medicaid Plan, and sets forth policy and procedures through rules and regulations in implementing the plan. The single state agency serves as the primary point of contact with the federal government agency; provides or oversees the provision of Medicaid eligibility determination and processes; oversees policies, rules, and operations carried out by Medicaid; and monitors and oversees the Medicaid budget. The single state agency in Florida responsible for administering the Medicaid program is the Agency for Health Care Administration (AHCA).

Financing

The states and the federal government jointly finance the Medicaid program. Medicaid is an entitlement program. The number of people participating in the program and services provided determine state and federal spending levels. If Medicaid eligible recipients need services covered under the Medicaid program the state and the federal government must provide funding for the service.

State funding for Medicaid comes from general revenues. Some states, including Florida, rely upon a combination of state and local funding sources to provide the required

matching funds. The federal financial participation (FFP) is the amount that the federal government matches for each state dollar spent on the program. The FFP matching rate varies from state to state and year to year because it is based on the average per capita income in each state. States with lower per capita incomes relative to the national average receive a higher federal matching rate. Currently the FFP in Florida is 57 percent; therefore, Florida receives \$0.57 for each state dollar spent for Medicaid services provided to a Medicaid-eligible individual. For most of the services and supports referenced in this report, Florida uses state general revenue for most of its matching funds. Florida counties do provide matching funds for a limited array of Medicaid covered services such as nursing homes.

Many of the supports that are needed by Medicaid recipients who are homeless or at risk of homelessness are reimbursed using a fee for service payment methodology. Organizations providing these services and supports must first provide the service and submit a “claim” to Medicaid to receive payment. Payments are made to these organizations based on the amount of time the individual received the service and a statewide fee schedule that pays all providers of a given service the same rate. There are some rules that limit the amount AHCA will reimburse providers.

Support Services Covered

There are a variety of supports and services that are covered under various Medicaid programs for the target populations covered under this report. These services and supports can be provided to Medicaid recipients for:

- Locating and maintaining housing through case management programs;
- Offering meaningful and effective opportunities to develop or redevelop the skills necessary to maintain their housing (e.g., money management, illness management, even employment supports);
- Supporting individuals during crisis when they may be most at risk of losing their housing and other benefits; and
- Offering supports for individuals to develop the necessary skills for employment.

Several Medicaid programs offer great flexibility as to where these services and supports can be delivered, including an individual’s home, work or other natural environment. Medicaid services are always subject to medical necessity. Medically necessary or medical necessity means that the rehabilitative services furnished must meet all five of the conditions listed below. They must be:

- Necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
- Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;
- Consistent with generally accepted medical standards as determined by the Medicaid program, and not experimental or investigational;

- Reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
- Furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caretaker, or the provider.

Florida’s Medicaid program includes several key service categories that can be used to support individuals in supportive housing. These services include:

- Mental Health Targeted Case Management
- Intensive Case management
- Mental Health and Substance Abuse Rehabilitative Services
- Assertive Community Treatment
- Developmental Disabilities Home and Community-Based Waivers

Medicaid generally does not cover room and board or job-specific vocational services. Tenancy supports are not a specific service definition within Medicaid, but tenancy supports in general can be provided under several of the Medicaid service definitions outlined below. Supported employment services are only available to individuals with developmental disabilities.

Medicaid does not cover services for adults with mental illness between the ages of 18 and 64 when provided in an Institution for Mental Disease (IMD). Specifically, the IMD exclusion precludes Medicaid reimbursement, and any federal matching dollars, for services received by individuals in facilities that meet the IMD criteria. A facility meets the IMD criteria when they:

- Have more than sixteen beds;
- Specialize in the treatment of persons with mental illnesses or addictive disorders; and
- Are licensed or accredited as a psychiatric facility.

Generally, the IMD exclusion pertains to public and private psychiatric hospitals and residential substance abuse programs.

Medicaid Targeted Case Management

Description of the Service

Targeted Case Management (TCM) is an activity that assists individuals eligible for Medicaid in gaining access to necessary care and services appropriate to the needs of an individual. Case management services are referred to as targeted case management services when the services are provided only to a defined or “targeted” group of people versus every Medicaid recipient. The state can also be prescriptive as to who can provide targeted case management services. This flexibility enables states to target case

management services to specific individuals or to individuals who reside in specified areas. The purpose of targeted case management is to assist Medicaid recipients in gaining access to needed medical, social, educational and other services.

There is only one case management program that Florida offers to a population covered in this report, Mental Health Targeted Case Management. The primary goal of mental health targeted case management is to optimize the functioning of recipients who have complex needs by coordinating the provision of quality treatment and supportive services in the most efficient and effective manner. These services include working with the recipient and the recipient's natural support system to develop and implement the recipient's service plan. The following service activities are covered for all target groups:

- Developing the assessment and service plan.
- Working with the recipient and the recipient's family to implement the service plan.
- Assessing the effectiveness of the service plan in meeting the identified needs of the recipient.
- Linking the recipient with services and resources identified in the service plan.
- Advocating for the acquisition of services and resources necessary to implement the service plan.
- Coordinating the delivery of services as specified in the service plan with the help of the recipient, the recipient's family, and the recipient's natural support system.
- Monitoring service delivery to evaluate the recipient's progress.
- Facilitating access to needed services documented in the service plan.
- Travel time spent by the mental health case manager to provide reimbursable mental health targeted case management services.
- Arranging for and coordinating aftercare services upon discharge from a residential or inpatient facility.

Medicaid will not reimburse mental health targeted case management services for the provision of hands-on, direct therapeutic medical or clinical services (e.g., providing psychotherapy or skill building services). Medicaid will not reimburse mental health targeted case management services for administrative functions (e.g., checking recipient eligibility or clerical duties).

Targeted case management are authorized under Section 1915 (g) of the Social Security Act. The Florida Medicaid targeted case management program was implemented through Chapter 409, Florida Statutes and Chapter 59G, Florida Administrative Code.

Eligibility/Populations Covered

To receive mental health targeted case management services, a recipient must be in one of the specific target groups described below:

- Children’s mental health targeted case management for recipients birth through 17 years old.
- Adult mental health targeted case management for recipients 18 years and older.

To receive TCM services an individual must be “certified” by AHCA. To be certified to receive TCM services, an individual must have a disability that requires advocacy for and coordination of services to maintain or improve level of functioning. The disability must last for a minimum of one year. In addition, the individual must require services to assist in attaining self-sufficiency and satisfaction in the living, learning, work, and social environments of choice and lack a natural support system with the ability to access needed medical, social, educational, and other services. Children can be eligible if they have a mental illness and are in an out-of-home mental health placement or at documented risk of out-of-home mental health treatment placement.

Provider Requirements

Mental health targeted case management services must be provided by a case manager employed by an agency that is enrolled as a mental health targeted case management agency and are certified to provide TCM to children, families or adults by DCF. The agency must also have a current contract with the district Department of Children and Families, Substance Abuse and Mental Health (SAMH) program office for the provision of community mental health or targeted case management services. The agency must also be certified by the district SAMH program office for the specific target group(s) that the agency will serve. To be certified as a mental health targeted case manager an individual must have various qualifications and competencies. For instance, targeted case managers must have a bachelor’s degree from an accredited university or college with a major in one of various human service fields (e.g., social work, psychology). In addition they must have a minimum of one year of full-time or equivalent experience working with children with serious emotional disturbances or adults with serious mental illness. If they do not meet these criteria, they must have a bachelor’s degree and three years full-time or equivalent experience or appropriate training.

Medicaid will not reimburse for mental health targeted case management services under certain conditions. For instance, Medicaid will not reimburse mental health targeted case management for transporting recipients. The Medicaid transportation program reimburses for transportation of recipients to obtain medically necessary, Medicaid-covered services.

Medicaid Intensive Case Management

Description of Services

Intensive case management team services provide team case management to adults with serious and persistent mental illness to assist the recipient to remain in the community and avoid institutional care. Intensive team case managers coordinate needs assessment, services planning, and provide service oversight.

Populations/Eligible

In order to receive ***intensive case management team services***, a recipient must be certified by the district SAMH program office. In addition, the recipient must meet at least one of the following requirements:

- Has resided in a state mental hospital for at least six months in the past 36 months;
- Resides in the community and has had two or more admissions to a state mental hospital in the past 36 months;
- Resides in the community and has had three or more admissions to a crisis stabilization unit (CSU), short-term residential facility (SRT), inpatient psychiatric unit, or any combination of these facilities within the past 12 months; or
- Resides in the community and, due to a mental illness, exhibits behavior or symptoms that could result in long-term hospitalization if frequent interventions for an extended period of time were not provided.

Provider

To be certified as an adult mental health intensive team case management services agency, the agency must respond 24 hours a day, 7 days a week to the needs of recipients served by the team. In addition the team must maintain no more than a maximum average caseload size of 15 recipients per each team case manager.

Medicaid Mental Health and Substance Abuse Rehabilitative Services

Description of the Service

Many critical services and supports needed by Medicaid recipients with significant mental health and substance abuse needs can be covered under Florida's Rehabilitative Services program. Mental Health and Substance Abuse Rehabilitative Services are included in Florida's Medicaid Rehabilitation Option. The Medicaid Rehabilitation Option (the "Rehab Option") refers to the optional rehabilitative services that a state Medicaid program may add to its state Medicaid plan. Rehabilitative services are defined in 42 CFR §440.130 as "any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level." Over the past ten years Florida has used the rehabilitation option to finance various services that support individuals with mental illnesses and addictive disorders to function more independently in the community.

The Florida Medicaid community mental health program has 13 categories of mental health and substance abuse rehabilitative services for Medicaid recipients. Included in these categories are various rehabilitative services. Rehabilitative services consist of social rehabilitation and counseling and basic living skills training. These services can

be provided on an individual basis or to groups of individuals, and focus on redevelopment of communication skills and other independent living skills (e.g., symptom management, food planning, etc.). This category is designed to provide flexibility as to where these services can be delivered to individuals (e.g., home, work, school, or other settings). It is similar to many states' community support programs. The rehabilitative services are most applicable for supporting individuals with a mental illness and/or addictive disorder in supportive housing.

Rehabilitative services are intended to enhance Medicaid recipients' functioning if they have a mental illness or substance abuse disorder. Rehabilitative services are specifically intended to restore a recipient's previous level of functioning. There are three critical services that can be used to provide "hands on" skill building and supportive counseling to individuals in their home and natural environment including work. These services include:

- ***Social rehabilitation and counseling*** are targeted to adults and include redevelopment of communication and socialization skills and techniques; and counseling and therapy services that are directed toward the elimination of psychosocial barriers that impede the redevelopment or modification of skills necessary for independent functioning.
- ***Basic living skills training*** are targeted to adults and promote the redevelopment or restoration of those skills necessary to increase independent functioning in community settings. Examples of basic living skills are food planning and preparation, maintenance of living environment, community awareness and mobility skills, and patient education regarding symptom management.
- ***Home and community-based rehabilitative services*** are specifically targeted to children and adolescents and are designed for the restoration, modification, and maintenance of social, personal adjustment, and basic living skills. The lack of these skills must be directly related to the recipient's mental health or substance abuse disorder. These services are designed to assure that the child possesses the physical, emotional, and intellectual skills to live, learn, and work in the child's own particular environment. This service could be used to assist transition-age youth with a mental health and/or substance abuse disorder to build the skills necessary to live independently in the community.

Skill building and supportive counseling can be provided in a structured program through Rehabilitation ***Day Treatment***. Rehabilitation Day Treatment consists of a **structured program of** social rehabilitation and basic living skills training. The primary focus of rehabilitative day treatment services is:

- Redevelopment/restoration of communication and social skills to overcome barriers that prevent independent functioning;
- Redeveloping the skills necessary to increase independent living in community settings; and

- Redeveloping skills required to maintain a living environment, use community resources and carry out activities of daily living.

Eligibility/Populations Covered

To receive mental health or substance abuse rehabilitative services an individual must be a current Medicaid recipient and have a specific mental health and/or substance abuse diagnosis established by the state of Florida.

Individuals with a diagnosis of mental retardation or a pervasive developmental disorder are not eligible for services under the mental health and substance abuse rehabilitative program. In addition, recipients that have an organic brain disorder (dementia or delirium) or other psychiatric or neurological conditions that prohibit communications may not be eligible for these services.

Provider Requirements

To be eligible to enroll in Medicaid's community mental health services program, providers must have a current contract to provide community mental health services from the district Department of Children and Families, Substance Abuse and Mental Health (SAMH) program office. They must also employ or have under contract a Medicaid-enrolled psychiatrist or other physician. Alcohol prevention, treatment, or drug abuse treatment and prevention programs must hold a regular (i.e., not probationary or interim) license.

Social rehabilitation counseling, basic living skills training and rehabilitative day treatment must be, at a minimum, rendered by a community mental health or substance abuse technician under the supervision of a community mental health practitioner or certified addiction professional. Home and community-based rehabilitative services, must at a minimum be rendered by a mental health technician or a substance abuse counselor.

Service Limitations

All social and rehabilitative services must be provided face-to-face with the recipient. AHCA has also established specific monthly or annual limitations on the number of units of social and rehabilitative services an individual may receive. AHCA also determines which service combinations cannot be reimbursed when they are provided on the same day. Social rehabilitation counseling and basic living skills training can be provided one-on-one or in groups. Requests for exceptions to many service limits and service

combinations may only be made for children. These requests must be submitted and approved by AHCA.

Medicaid Florida Assertive Community Treatment Program

Description of Services

A Florida Assertive Community Treatment (FACT) team is a self-contained mental health program made up of a multidisciplinary mental health staff, including a peer specialist, that works as a team to provide the majority of treatment, rehabilitation, and support services clients need to achieve their goals. FACT services are individually tailored with each client through relationship building, individualized assessment and planning, and active involvement with clients to enable each to find and live in their own residence, to find and maintain work in community jobs, to better manage symptoms, to achieve individual goals, and to maintain optimism and recover. The FACT team is mobile and delivers services in community locations rather than expecting the client to come to the program.

Eligible Populations

FACT serves clients with severe and persistent mental illnesses that are complex, have devastating effects on functioning, and, because of the limitations of traditional mental health services, may have gone without appropriate services. Consequently, the client group is often over-represented among the homeless and in jails and prisons, and has been unfairly thought to resist or avoid involvement in treatment. There should be no more than 8-10 clients to one staff member.

Covered Services and Supports

The FACT team is mobile and delivers services in community locations to enable each client to find and live in his/her own residence and find and maintain work in community jobs rather than expecting the client to come to the program. Seventy-five percent or more of the services are provided outside of the program offices in locations that are comfortable and convenient for clients. Services provided by FACT teams include:

- Assessment and treatment planning
- Case management services
- Crisis assessment and intervention
- Symptom assessment, management and individual supportive therapy
- Medication prescription, administration, monitoring and documentation
- Substance abuse services
- Work related services
- Support in activities of daily living
- Social, interpersonal relationship and leisure time training and support
- Provide or arrange for safe, decent, affordable living arrangements

- Provide education, support and consultation to the person’s family and other major supports

Providers

FACT programs are funded by DCF and must meet the requirements of the National Alliance for the Mentally Ill for Assertive Community Treatment (ACT). ACT services are delivered by a group of multidisciplinary mental health staff who work as a team and provide the majority of the treatment, rehabilitation, and support services clients need to achieve their goals. The team is directed by a team leader and a psychiatrist and includes a sufficient number of staff from the core mental health disciplines, at least one peer specialist, and program/administrative support staff who work in shifts to cover 24 hours a day, 7 days a week to provide intensive services (contacts may be as frequent as two to three times per day, seven days per week, based on client need and a mutually agreed upon plan between the client and ACT staff). Many, if not all, staff share responsibility for addressing the needs of all clients requiring frequent contact.

Medicaid Managed Care and Behavioral Health

Beginning in the early 1990s, states began shifting the delivery of Medicaid services to managed care service delivery models. Some states implemented broad state “health care reform” initiatives that were designed to extend health services to uninsured individuals who could not otherwise qualify for Medicaid (e.g., low-income childless adults). These initiatives were coupled with extensive use of managed care in order to secure cost savings that could be used to underwrite services to additional individuals.

Massachusetts (Mass Health) and Oregon (Oregon Health Plan) were among the states that pioneered such initiatives. Elsewhere, states saw managed care mainly as a cost containment device to slow the rapid increase in Medicaid spending and/or address other issues in the delivery of services to beneficiaries. In order to expand the use of managed care in their Medicaid programs, states had to obtain federal waivers. These waivers are necessary for states to mandate that beneficiaries enroll in a managed care plan and selectively contract with managed care organizations to deliver services. Federal waivers also are necessary when a state wishes to extend services to populations that cannot be covered using existing statutory authorities or implement alternative service delivery strategies that depart from statutory requirements.

Medicaid mental health services also were affected by the expanded use of managed care. A number of states, including Florida, shifted the delivery of Medicaid mental health services to managed care arrangements. Some states contracted with private sector behavioral health companies to take over the provision of Medicaid mental health services. Elsewhere, states overlaid managed care contracting onto their community mental health systems, with public and/or non-profit mental health organizations (sometimes in partnership with private sector companies) becoming managed care contractors.

There are several Medicaid managed care initiatives that affect the delivery of mental health and substance abuse services to individuals enrolled in the Medicaid program. Two demonstration sites in AHCA areas 1 and 6 were selected to test new models for managing, integrating and delivering mental health and substance abuse services. The managed care model requires that AHCA contract with a managing entity to develop and coordinate the necessary mental health services. These managing entities would receive a prepaid, fixed sum payment from AHCA based on the historic Medicaid expenditures for mental health and substance abuse services. In essence, funding for these services are “capped” for current and future years—unlike the more open-ended expenditures for programs described earlier in this section (targeted case management, rehabilitative services and FACT).

Developmental Services Covered Under Medicaid Home and Community-Based Waivers

Description of the Service

Services and supports that can assist individuals with developmental disabilities to obtain and maintain supportive housing can be accessed through Florida’s Medicaid Home and Community-Based Services Waivers (HCBS). States offer home and community services to individuals who otherwise qualify for services furnished in a nursing facility, intermediate care facility for the mentally retarded or a hospital. Individuals who meet the level of care requirements for these Medicaid institutional settings may instead be offered home and community services when a state operates an HCBS waiver program. Individuals must affirmatively elect to receive home and community services in lieu of institutional services.

States have employed the HCBS waiver program extensively to promote the cost-effective delivery of long-term services to many Medicaid beneficiary target population groups. The cost of furnishing community services has been demonstrated to be considerably lower than institutional services. In addition, the program is very flexible. States have wide-ranging latitude in selecting the populations to which they will furnish services and in the services that they offer through their programs. In most instances, states have more generous eligibility rules for individuals to qualify for HCBS services. For instance, in Florida, individuals with incomes up to 300 percent of the federal poverty level can qualify for these services. As indicated previously, most individuals must have incomes at or below 185 percent of the federal poverty level to be eligible for Medicaid.

Several services that states offer through an HCBS waiver program including case management, personal care, habilitation, adult day health, homemaker/home health aide and respite. States also may cover additional services and supports so long as they contribute to assisting individuals to avoid institutionalization. A state is barred from claiming the costs of “room and board” (e.g., housing and other routine living expenses) furnished to waiver participants. Such expenses must be met from the beneficiary’s own

resources (e.g., SSI payments) or other funds. In addition, all services provided through a waiver program must be spelled out in a “plan of care.” The plan of care also identifies other services and supports (paid and unpaid) that are integral to supporting the person in the community. In proposing to operate a waiver program, a state specifies the number of individuals it plans to serve. A state is not obligated to furnish services to additional persons once it reaches its self-imposed enrollment cap. However, there are no federal limits on how many individuals a state may serve in a waiver program.

Florida has three 1915 (c) Waivers that offer many of these services. These Waivers include:

- Developmental Services Waiver, which serves approximately 27,000 individuals.
- Consumer Directed Care Initiative (soon to be the Independence Plus Initiative) serving 2,000 individuals.
- Supported Living Waiver soon to be the Family and Supported Living Waiver. This Waiver is the smallest of all three—serving only six individuals.

Covered Supports and Services

There are specific nuances to each of the Waivers. The HCBS waiver contains 34 services, all of which are also available under the CDC waiver. The Supported Living Waiver is limited to five core services: In Home Supports, Supported Living coaching, Transportation, Supported Employment or Adult Day Training. Examples of supports offered under the HCBS and CDC waivers are:

- ***In-Home Support Services*** are services provided to a recipient in a supported living situation with 4- to 24-hour a day assistance from a support worker or workers. Support workers can be an individual or a staff person from an agency. Support workers must have at least one year experience working in a medical, psychiatric, nursing or childcare setting or working with individuals who have a developmental disability. The support worker provides companionship and personal care, and may assist with or perform activities of daily living and other duties necessary to maintain the beneficiary in supported living.
- ***Personal Care Assistance*** is a service that assists a recipient with eating and meal preparation, dressing, bathing, personal hygiene, and activities of daily living. The services may also include vacuuming and bed making when these activities are essential to the health and welfare of the beneficiary and when there is no one else to perform them.
- ***Homemaker Services*** are those household activities such as meal preparation, laundry, vacuuming and routine household cleaning provided by a trained homemaker, when the person who usually handles these tasks is unable to perform them. The intent of this service is to ensure that the beneficiary’s home environment remains safe, clean and sanitary.
- ***Companion Services*** consist of supervision and socialization activities and may assist the beneficiary with such tasks as meal preparation, laundry and shopping.

This service may also include light housekeeping tasks. Other examples of companion services provided include going to the library, getting a library card, shopping for groceries, or going to an animal shelter to learn about animals.

- **Chore Services** are provided to maintain the recipient's property as a clean, sanitary and safe environment. These services include heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, replacing broken windows or moving heavy furniture to make the home safer.
- **Residential Habilitation Services** provide specific training activities that assist the beneficiary to acquire, maintain or improve skills related to activities of daily living. The service focuses on personal hygiene skills such as bathing and oral hygiene; homemaking skills such as food preparation, vacuuming and laundry; and on social and adaptive skills that enable the beneficiary to reside in the community.
- **Support Coordination** is the service of advocating, identifying, developing, coordinating and accessing supports and services on behalf of a beneficiary, or assisting the beneficiary or family to access supports and services on their own. These services may be provided through waiver and other Medicaid State Plan services, as well as needed medical, social, educational, other appropriate services, and community resources regardless of the funding source through which access is gained. The waiver support coordinator is responsible for assessing a beneficiary's needs, preferences and future goals (outcomes). From that information, the waiver support coordinator assists the beneficiary in developing a support plan and cost plan.
- **Supported Living Coaching** services provide training and assistance, in a variety of activities, to support beneficiaries who live in their own homes or apartments. These services may include assistance with locating appropriate housing, the acquisition, retention or improvement of skills related to activities of daily living such as personal hygiene and grooming, household chores, meal preparation, shopping, personal finances and the social and adaptive skills necessary to enable beneficiaries to reside on their own.
- **Supported employment** services provide training and assistance in a variety of activities to support beneficiaries in sustaining paid employment. The supported employment provider assists with the acquisition, retention or improvement of skills related to accessing and maintaining such employment. With the assistance of the supported employment provider, the beneficiary is assisted in securing employment according to their desired outcomes, including the type of work environment, activities, hours of work, level of pay and supports needed. Supported employment is conducted in a variety of settings, to include work sites in which individuals without disabilities are employed.

The Developmental Services Home and Community-Based Waivers are authorized under Section 1915(c) of the Social Security Act and governed by Title 42 CFR, Part 441.300.

The Florida Medicaid Developmental Services Waiver is authorized under Chapter 409 and Chapter 59-8 200 of the Florida Administrative Code.

Eligibility/Populations Covered

To receive developmental services under the Medicaid Waiver an individual must be a current Medicaid recipient and meet the eligibility requirements of the Developmental Services Program. This criterion includes:

- The beneficiary's intelligence quotient (IQ) is 59 or less; or
- The beneficiary's IQ is 60-69 inclusive and the beneficiary has a secondary handicapping condition, that includes cerebral palsy, spina bifida, Prader-Willi syndrome, epilepsy, autism, or ambulation, sensory, chronic health, and behavioral problems, or the beneficiaries IQ is 60-69 inclusive and the beneficiary has severe functional limitations in at least three major life activities including self-care, learning, mobility, self direction, understanding and use of language, and capacity for independent living; or
- The beneficiary is eligible under a primary disability of autism, cerebral palsy, spina bifida, or Prader-Willi syndrome. In addition, the condition must result in substantial functional limitations in three or more major life activities, including self-care, learning, mobility, self-direction, understanding and use of language, and capacity for independent living.

Individuals must also meet the level of care criteria for placement in an Intermediate Care Facility for the Developmentally Disabled (ICF/DD).

Providers

Waiver provider applicants must meet specific qualifications and requirements before becoming eligible to provide services. Each provider must be certified by the Agency for Persons with Disabilities (formerly DCF's Developmental Disabilities program office) prior to enrolling as a provider.

Service offered under the HCBS program can be rendered by an agency or independent vendor. DCF defines an agency as a business, organization or entity enrolled to provide a waiver service(s) that has one or more staff employed to carry out the enrolled service(s). All employees of an agency or group provider must meet the qualifications and requirements specified in the provider's agreement and those specified for enrolled service(s). An independent vendor is an agency that employs individuals or an individual who meets specified qualifications of certain career service classification codes or holds local occupational licenses.

In some instances, an individual person or a "solo provider" can offer services. A solo provider is an eligible provider who personally renders waiver services directly to beneficiaries and does not employ others to render waiver services.

The chart in Attachment A provides a brief summary of qualifications for relevant services and supports needed by individuals with developmental disabilities in supportive housing.

Perhaps one of the most relevant services for individuals with developmental disabilities in supportive housing is **Support Coordination**. There are many requirements that govern this service regardless of whether an agency or solo provider offers this service. An enrolled waiver provider of support coordination services is selected by the beneficiary enrolled in the waiver (or their guardian) to assist the beneficiary in gaining access to needed waiver and Medicaid State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained. In the absence of a selection by the beneficiary or guardian, waiver support coordinators may be assigned by the District (subject to the beneficiary or guardian making a different selection at a later date).

Waiver support coordinators are responsible for ongoing monitoring of supports and services to ensure they are provided to meet the beneficiaries' needs. They also initiate and oversee the process of assessment and reassessment of the beneficiaries' level of care and the review of support plans.

Solo providers and waiver support coordination supervisors employed by agencies shall meet the minimum education qualifications including a bachelor's degree from an accredited college or university and three years of professional experience in developmental disabilities, special education, mental health, counseling, guidance, social work or health and rehabilitative services. A master's degree can substitute for one year of the required experience.

< **Mental Health Block Grant** >

Description of the Program

Public Law 102-321 establishes the Federal Block Grant for Mental Health Services. This federal funding program is administered by the Center for Mental Health Services (CMHS), a division of the Substance Abuse and Mental Health Services Administration, United States Department of Health and Human Services. The Mental Health Block Grant program supports comprehensive, community-based systems of care for adults with serious mental illnesses and children with serious emotional disturbances. The program was established in 1981 and is one of the cornerstones of Federal efforts to work in partnership with the States to plan and deliver systems of community-based mental services for adults and children. The Mental Health Block Grant program is the single largest "earmarked" Federal contribution dedicated toward improving mental health service systems across the country.

Eligibility

The Mental Health Block Grant application and award requires that states use these funds for various populations who need mental health services. These populations include:

- Adults with severe and persistent mental illness (SMI)
- Adults in mental health crisis
- Adults with forensic involvement
- Homeless persons with SMI (or SED) and who receive mental health services
- Children with serious emotional disturbances (SED)
- Children with emotional disturbances or at risk of emotional disturbances

CMHS generally requests that states use the federal definition for two populations: adults with serious mental illness and children with serious emotional disturbances. The definition CMHS uses for children with serious emotional disturbances is a person from birth to eighteen who currently has, or at any time during the past year had, a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic categories and that resulted in a functional impairment, which substantially interferes with or limits the child's role or functioning in family, school, or community activities. The CMHS definition of adults with serious mental illness mirrors the SED definition, the difference being the ages to which it applies (over eighteen).

States do have the option of using other definitions for these two populations; however, states must explain why they are different from the Federal definitions. Florida uses the federal definition of adults with serious mental illness and children with serious emotional disturbances.

Administrative Agency

The Center for Mental Health Services is the Federal agency that oversees the Mental Health Block Grant. The Community Mental Health Services Block Grant is authorized by Part B of Title XIX of the Public Health Service Act. The federal statute establishing this program requires the funds to be expended through the state's public mental health system. In Florida, The Department of Children and Families, Mental Health Program Office, is the recipient of the Federal Block Grant.

Financing

All States are eligible for the grant program. Each selected State will receive a formula grant allotment from the Substance Abuse and Mental Health Services Administration. Each year, Florida applies for an award under this program and currently receives an annual grant of approximately \$26 million.

Grants are awarded to states based on a variety of program requirements. States are required to develop annual plans that must include goals, objectives, and performance

indicators for improving community-based services. State Mental Health Plans must address the need for services among special populations and must describe the financial and human resources required for implementation.

In addition, each State must also agree to maintain expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the two-year period preceding the fiscal year for which the State is applying for the grant. Unlike other federal programs, there is no required state match for the Mental Health Block Grant.

Support Services Covered

The federal block grant program stipulates that case management be provided to individuals with the most serious mental disorders and encourages appropriate partnerships among a wide range of health, dental, mental health, vocational, housing, and educational services. In Florida, the CMHS block grant funds are used to fund the following services:

- **Case Management**—These services are activities aimed at identifying a person’s needs, planning services, linking the system with the person, coordinating the various system components, monitoring service delivery and evaluating the effects of the services received.
- **Community Support**—These services assist a person’s successful integration into the community and may range from residential services to transportation and other ancillary services and supports.
- **Florida Assertive Community Treatment (FACT)**—FACT Teams provide non-residential care services available 24 hours a day, 7 days a week. A multidisciplinary team incorporates community-based treatment, rehabilitation and support services to persons with severe mental illnesses.

Approximately \$10.2 of the \$26.8 million in federal block grant funds Florida receives are specifically for case management, community support and assertive community treatment. Of the \$10.2 million for support services, \$6.7 million is for adults and \$3.4 million for children.

Providers

Mental health and substance abuse services funded with federal block grant funds are rendered through an array of providers, which include 114 mental health service providers. The block grant funds are not a “separate” funding source for providers.

Rather, DCF blends block grant and state general revenue funds to purchase community support, FACT and case management services.

Under the current contracting system, the DCF District enters into contracts with providers who are qualified to provide these services. The contracting process is initiated either through a competitive procurement process or individually negotiated process. The contract may be service specific (e.g., FACT) or may include several services (e.g., case management, residential, supported employment). The DCF district has the discretion to identify what services they will contract for based on local needs and preferences as identified through the local planning process.

< **SAPTBG** >
***Substance Abuse Prevention and
Treatment Block Grant***

The Substance Abuse Prevention and Treatment Block Grant (SAPTBG), the cornerstone of the States' substance-related programs, accounts for approximately 40 percent of public funds expended on substance prevention activities and treatment services. This grant program — with funds disbursed to the States, Territories, and the District of Columbia based on a congressionally mandated formula — is administered by the Center for Substance Abuse Prevention (CSAP) and its Center for Substance Abuse Treatment (CSAT). While the program enables States to provide substance abuse treatment and prevention services through a variety of means, both statute and regulations place special emphasis on provision of treatment and primary prevention services to both injecting drug users, and to substance abusing women who are pregnant or with dependent children. The Substance Abuse Prevention and Treatment (SAPT) Block Grant program goal is to support substance abuse prevention and treatment programs at the State and local levels. While the SAPT Block Grant provides Federal support to addiction prevention and treatment services nationally, it empowers States to design solutions to specific addiction problems that are experienced locally.

Substance Abuse Block Grant Target Populations

The SAPTBG requires that states submit an annual plan for substance abuse prevention and treatment services that reflect specific areas identified by the SAMHSA. The plan must include the following prevention and treatment services:

- Treatment for intravenous drug abusers
- Group homes for recovering substance abusers through the operation of a revolving loan fund
- Treatment for pregnant women
- HIV early intervention services, which includes education, counseling and testing especially for youth who use drugs and are at high risk for this disease
- Twenty percent of the award must be on primary prevention programs for individuals who do not require treatment for substance abuse

Support Services Covered

Funds from the SAPT Block Grant can be used to purchase a variety of services including outreach, aftercare, detoxification, outpatient counseling, residential rehabilitation including therapeutic community stays, hospital-based care, vocational counseling, case management, central intake, and program administration. Critical services covered under the SABL in Florida are described below.

- Aftercare services are designed to bridge the gap from treatment to the community through relapse prevention, and the promotion and support of positive

lifestyle changes and by solidifying gains made in treatment. The program provides individual and supportive group counseling, referral to other needed community resources and peer support.

- Case management services will include identifying the recipients needs, planning services, linking the services with the person, coordinating the treatment services, monitoring services delivery and evaluating effect of services received.
- Outpatient services are provided in a therapeutic environment designed to improve the functioning or prevent further deterioration of persons with mental health and/or substance abuse problems. Outpatient treatment may include individual, group and family therapy.
- Structured residential treatment services (24 hours a day, 7 days a week) for those individuals whose lives have been directly affected by substance abuse issues and need extensive support and supervision. Services will include an emphasis on assessment, treatment and rehabilitation that may include ancillary services and adult education.

Financing

In FY 03 the Substance Abuse Program Office received approximately \$96.1 million under the SAPT Block Grant. Approximately, \$60 million were specifically for substance abuse treatment and rehabilitation services. The other \$36.1 million were for prevention activities.

Similar to the MHBG the SAPT BG has a maintenance of effort requirement. States must agree to expend an amount equal or greater to the amount expended in the previous two years. This requires Florida to spend \$69 million in state general revenue funds (in addition to the \$60 million in federal block grant funds) on substance abuse prevention and treatment services.

Providers

The Substance Abuse Program Office of the Department of Children and Families contracted with over 190 community-based non-profit and public agencies through 15 district administrative offices. All facilities that provide substance abuse services funded either through the SAPT BG or general funds must be licensed. DCF is responsible for licensing substance abuse providers and ensuring compliance with federal block grant requirements. Providers are also required to implement their programs in accordance with the federal statutes and regulations covering the SAPT BG. These federal and state requirements are too voluminous to discuss in this document.

< *PATH* >
Projects for Assistance in Transition from Homelessness

Description of the Program

Projects for Assistance in Transition from Homelessness (PATH) was established by the Stuart B. McKinney Act of 1990. This federal grant program is administered by the Center for Mental Health Services (CMHS), a division of the Substance Abuse and Mental Health Services Administration, United States Department of Health and Human Services. The PATH program is intended to assist states to work with people who are homeless and have mental illness. Funds are provided to states on a formula grant basis, and may be used for outreach, mental health services, substance abuse services, case management, and other support services.

Eligibility

The PATH program does not have specific eligibility requirements. Generally, services funded with PATH grant funds must be targeted to homeless individuals and families who have mental illness or co-occurring mental illness and substance abuse. However, outreach and related PATH services may be provided to people who are homeless or at risk of homelessness that do not meet narrow federal or state definitions of serious mental illness or serious emotional disability.

Administrative Agency

The Center for Mental Health Services is the Federal agency that oversees the PATH program. In Florida, The Department of Children and Families, Mental Health Program Office, is the recipient of the Federal Block Grant. The contact point for information on PATH services is the Supportive Housing Coordinator within the DCF Mental Health program Office.

Financing

All States are eligible for the grant program. Each State receives a formula grant allotment from the CMHS. For PATH, the formula includes factors based on the proportion of urban population within the state compared to the total U.S. urban population.

The 2003 national appropriation for PATH was \$41.3 million. For 2004 this is projected to increase to \$50.1 million. In 2003 Florida received \$2.566 million in PATH funds. The PATH program requires that every \$3.00 in PATH grant funds must be matched by

\$1.00 cash or in-kind match from the states. In 2002, Florida committed \$978,268 in state match to PATH for a total of \$3.54 million.

Support Services Covered

PATH funds may be used to a variety of broad service categories. These include:

- Outreach
- Screening and diagnostic services
- Habilitation and rehabilitation services
- Community mental health services
- Alcohol or drug treatment services (for people with co-occurring substance use disorders)
- Case management
- Supervisory services in residential settings

In Florida, the agencies receiving PATH funds and delivering PATH services are typically Mental Health Centers or similar agencies that also provide services under the Mental Health Block Grant, state general fund appropriations, and Medicaid. Thus, it can be expected that the definitions used for the above services will be similar to Florida's services definitions for the other funding categories (for example, see the Mental Health Block Grant section of this report). However, as with the eligibility requirements, PATH is a very flexible program, and thus the services provided could be broader than the definitions used for other programs.

Providers

In 2002, 419 local organizations within states enrolled over 54,000 homeless or at-risk people for PATH services nationwide. In FY 2003-2004, DCF awarded PATH funds to 13 provider organizations. These were located in Tampa, Orlando, Jacksonville, Tallahassee, Miami, Naples, Fort Myers, Clearwater, Sarasota, West Palm Beach, Marathon, Lauderhill and St. Petersburg. Three new PATH programs will be implemented in Brevard, Seminole, and Osceola Counties in FY 2004-2005.

< *TANF* >
Temporary Assistance for Needy Families

TANF¹⁴ is a flexible block grant that replaced the former cash assistance entitlement program, Aid to Families with Dependent Children (AFDC). The general purposes of the TANF program are to:

- Provide assistance to needy families;
- End the dependence of needy parents by promoting job preparation, work and marriage;
- Prevent and reduce out-of-wedlock pregnancies; and
- Encourage the formation and maintenance of two-parent families.

States may spend TANF funds on a variety of support services including: job training, employment placement, childcare, transportation, education, substance-abuse and mental health services, rental assistance, case management services, and many other activities. Federal TANF funds may be used for services other than cash assistance, and to benefit others beyond families with dependent children (e.g., non-custodial parents such as homeless individuals).

TANF Eligibility

TANF is primarily targeted to families with dependent children. Single adults over 18, including those with disabilities, are typically not eligible for TANF (although pregnant women may begin receiving TANF benefits before the dependent child is born). To remain eligible for TANF the adult(s) must be engaged in employment-related services such as education or job search. People who fail to participate in employment or employment-related services may be financially sanctioned or terminated from benefits. There is a federally mandated lifetime limit of 60 months for the receipt of TANF benefits. However, Florida may exempt 20 percent of its TANF caseload from the 60-month limitation.

In Florida the applicant earnings limit is \$4,716 for a one-parent family of three (this eligibility threshold is adjusted for the number of parents or custodians and number of children under 18 in the household). Once enrolled, a one-parent family of three can

¹⁴ Congress established TANF in 1996 (the legislation was entitled the “Personal Responsibility and Work Opportunity Reconciliation Act” (PRWORA). The legislation for the TANF program was due to be reauthorized by Congress in 2003, but was not. While Congress may reauthorize TANF in 2004 and make substantial changes then, it has, in the meantime, extended the current legislation, with no substantial changes to the program.

have earned income up to \$9,672 per year.¹⁵ The asset limitation is \$2,000 regardless of family size or earned income.

Some families with minor children may be eligible for non-cash assistance such as employment services if their income is below 200 percent of the poverty level (currently about \$28,300 for a family of three in Florida). These services are typically accessed through the One-Stop Centers managed under Florida's 24 Regional Workforce Boards.¹⁶

Florida does provide a one-time \$400 grant to certain TANF-eligible families to prevent loss of housing. This may be used for utility payments, rent arrearages or security deposits. A one-time emergency assistance payment of up to \$1,000 may also be available, which could assist with prevention of loss of housing.

Administering Agency

The Florida Department of Children and Families (DCF) is the administering agency for the Florida TANF block grant. In 2002, the Florida DCF reported serving 59,013 families representing 123,247 individuals, with total expenditures of \$255.9 Million.

Financing

States receive an annual TANF block grant from HHS and must also maintain a historical level of state spending known as "maintenance of effort." Because TANF is a block grant, the amount received by Florida is fixed, and cannot be increased even if more families are found to be eligible for assistance. Florida's annual expenditures for TANF cannot go below the maintenance of effort level, but theoretically could exceed that level if enrollment-related costs exceed the federal block grant level.

While the federal legislation allows for flexibility in the type of services that may be funded, many states need their TANF funds for cash assistance and directly related services, and use other resources such as Medicaid, state dollars, and the like to fund substance abuse counseling, mental health services, etc. If TANF caseloads are declining in a state, then funds previously spent on cash assistance may be available for other TANF activities. In Florida, TANF caseloads have been declining since 1994. Recent information from the federal Department of Health and Human Services indicated that Florida's TANF caseload has decreased from 200,000 in 1997 to 56,000 in 2001, a decrease of 72 percent.¹⁷

¹⁵ Note: these income thresholds change on an annual basis, and there are many ways in which income may be adjusted before calculating financial eligibility. Thus, it is always best to submit an application for eligibility, even if the income appears to be too high.

¹⁶ For more information on the one-stop centers see the Employment Services Section of this Report.

¹⁷ Indicators of Welfare Dependence, Annual Report to the Congress, U.S. Department of Health and Human Services 2002.

Support Services Covered

The goals of the TANF support services are to assist the family in achieving and maintaining economic and family stability. A wide variety of services are available to tailor to the needs of the identified individual including case management services, aftercare services, and supported employment.

TANF-eligible individuals can receive employment services through the 24 Florida Regional Workforce Boards and One-Stop Career Centers. Adults move toward work and independence from financial assistance by progressing through the four phases of the services component: application phase, pre-work-ready phase, work-ready phase, and employment phase. Participation in each of the second and third phases is limited to 12 cumulative months for each adult during a lifetime. Not all adults will spend 12 months in each of these phases; many will spend only a short time in them, and some will skip the work-ready phase. Unless granted an extension, not to exceed six months, any adult participant who has not advanced to the work-ready phase after having received 12 cumulative months of financial assistance shall be deemed work ready. Before participants are work-ready, they engage in any work activities they can perform, including remedial education or job skills training, as long as the activity leads to attainment of the participant's employment goal. Work-ready participants may take part in a vocational education program if they can complete the program within 12 months of becoming work-ready.

Job search is an appropriate activity for any participant seeking unsubsidized employment. Generally, participants may count this activity toward meeting their work requirement for only six weeks during the federal fiscal year. Only four of the six weeks may be consecutive. If no unsubsidized job is available, the participant shall accept a subsidized job or participate in a community service placement or a combination of work activities as approved by the case manager.

It should be emphasized that TANF will pay for certain ancillary services, such as child care and transportation, which are not normally available through traditional employment programs.

TANF also reimburses for mental health and substance abuse services. Specific covered services include:

- **Case Management**—Case management services consist of activities aimed at identifying the recipient's needs, planning services, linking the service system with the person, coordinating the various system components, monitoring service delivery, and evaluating the effect of the services received.
- **Aftercare services** include, but are not limited to, relapse prevention and are a vital part of recovery in every treatment level. Aftercare activities include client participation in daily activity functions that were adversely affected by mental illness and/or substance abuse impairments. New directional goals such as vocational education or re-building relationships are often priorities. Relapse

prevention issues are key in assisting the client's recognition of triggers and warning signs of regression. Aftercare services help families and pro-social support systems reinforce a healthy living environment.

- ***Employment and supported employment services*** are community-based employment services in an integrated work setting that provide regular contact with non-disabled co-workers or the public. A job coach provides long-term, ongoing support for as long as it is needed to enable the recipient to maintain employment.

< *Welfare to Work* >

The Federal Welfare-to-Work (WtW) program was created Under the Balanced Budget Act of 1997 to help move hard-to-employ welfare (TANF) recipients into lasting, unsubsidized jobs. In Florida the funds have been targeted to TANF cash and non-cash assistance recipients who: (a) are unemployed or underemployed or are having difficulty making child support payments; and (b) are connected to TANF or other types of assistance (e.g., minor child[ren] receiving TANF, Food Stamps, SSI, Medicaid or CHIP); and (c) must enter into a personal responsibility contract.¹⁸ Individuals at least 18 years of age but not yet 25 years of age who were in foster care are also eligible for WtW services in certain circumstances.

Administrative Agency

The Welfare to Work (WtW) program is administered federally by the Department of Labor, Employment and Training Administration. In Florida WtW is administered by the State Department of Education, Division of Vocational Rehabilitation (DVR).

Financing

The Department of Labor awarded Welfare to Work grants (WtW) in fiscal years 1998 and 1999, and grantees were originally given three years to spend the funds. This three-year term was subsequently extended for an additional two years. Florida's WtW grant award for the five-year period was \$47 million.. As of 2003, a few states still had unspent funds, but this is reported not to be the case in Florida, at least at the state level.¹⁹

The WtW federal funds available to states are capped by an established formula. Seventy-five percent of WtW funds have been distributed as grants to states. For every two dollars of federal funds, states had to match one dollar. The remaining 25 percent was distributed as competitive grants directly to community groups with no matching requirements. States could retain 15 percent of WtW funds for administration and special projects, but 85 percent had to go to Workforce Investment Boards to address local needs.

¹⁸ The Personal Responsibility Contract typically contains an agreement to establishing paternity and a child support order; and agreement to participate in WtW services; and a specification of the WtW services to be provided.

¹⁹ Note that Florida's authority to spend these remaining WtW funds is likely to have been revoked in the Consolidated Appropriations Act of 2004.

Support Services Covered

Eligible employment-related activities include: on-the-job training, community service or work experience, wage subsidies, individual development accounts, vocational education, job preparation, job search assistance, and job retention supports. The majority of funds had to serve long-term welfare recipients who faced significant barriers to employment (e.g., no high school diploma, in need of substance abuse treatment, or poor work history). Funds could also be used to serve non-custodial parents.

Funds have been used in Florida for the following activities:

- Outreach, recruitment, intake assessments, eligibility determination, development of an individualized employment service strategy, and case management
- On-the-Job Training (Job club, employment preparation, self-employment training)
- Subsidized public service employment
- Unsubsidized employment
- Community Service Experience
- Post-Employment Services (Adult Education Services, Vocational training, Occupational skills training; English as a second language)
- Job retention and support (transportation assistance; substance abuse treatment [see TANF substance abuse service descriptions]; child care; emergency housing assistance)
- Supportive Services (childcare, housing, transportation, mental health, etc.)

< *Workforce Investment Act* >

The Workforce Investment Act (WIA) of 1998 supersedes the Job Training Partnership Act (JTPA). WIA authorized many things including the creation of the One Stop Career Centers/Systems. WIA requires that states establish a “state workforce investment board to assist in the development of the State plan and to carry out other functions...”

Administering Agency

The Federal Workforce Investment Act (WIA) is administered under the Employment and Training Administration (ETA), which is a division of the U.S. Department of Labor (DOL). In Florida, the Workforce Investment Act (WIA) and related state and federal welfare reform (TANF, Welfare to Work) and specialized employment initiatives are managed through the State Department of Education, Division of Vocational Rehabilitation (DVR).²⁰

Financing

In 2001–2002 over 73,000 individuals in Florida received \$108.5 million of direct employment-related services through the Regional Workforce Board/One-Stop Career Center System. An additional \$29 million was spent during 2001-2002 for state-level direct employment services. Of these 73,000 individuals, over 32,000 adults enrolled in workforce training under the WIA.

Eligible Populations

All adults, 18 years and older, are eligible for core services. Youth between the ages of 14–21 who are transitioning from school to employment or are no longer in school may also be eligible for services from the One Stop Career Resource Centers.

Priority for employment services is given to recipients of public assistance (TANF) and other low-income individuals. While the focus is on serving unemployed adults, some adults with marginal jobs may be assisted to find or keep a job that allows for self-sufficiency. State and local areas set the guidelines to be followed concerning the priority and self-sufficiency requirements. The eligibility and priority for employment services determination is conducted by the One Stop Career Centers, and there may be some variability in priorities among One Stop Centers based on local economic and workforce conditions. For example, some One Stop Centers may give a priority to migrant farm workers, while other One Stop Centers may give a priority to workers displaced by factory closings. Nonetheless, people on TANF or associated with TANF (such as non-custodial parents with child support obligations) must receive a priority for access to employment services through the One Stop Centers.

²⁰ Phone Number for information: (800) 451-4327

Priority for access to DVR services is based upon the presence of a physical or mental impairment and a goal of employment. In general, eligible individuals meet the following criteria:

- The physical or mental impairment constitutes or results in a substantial impediment to employment; and
- The individual’s employment outcome can benefit from vocational rehabilitation services; and
- The individual requires vocational rehabilitation services to prepare for, to get, to keep, or to regain employment; or
- The individual is a recipient of Social Security Disability (SSDI) or Supplemental Security Income (SSI) and is seeking employment.

Support Services Covered

Core services include: outreach, initial assessment, job search and placement assistance, labor market information, and referrals to supportive services. “Intensive” services include: comprehensive assessments, development of individual employment plans, and counseling and career planning, work experience, and prevocational services. Individuals that cannot find employment using intensive services may be eligible for access to apprenticeship programs or on-the-job training. Supportive services, such as transportation, childcare assistance, and clothing may be available to enable an individual to participate in intensive services.

Providers

DVR funds 24 Regional Workforce Boards, which in turn fund and/or operate One Stop Career Centers.²¹ The One Stop Career Centers are the actual providers of employment-related services funded by the Workforce Investment Act, TANF and other employment programs. One Stop Career Centers in Florida provide the following types of employment services:

- Vocational Evaluation
- Job Placement
- Job Coaching
- Career Planning
- Supported Employment
- On-Site Job/Task Analysis
- Training and Education after High School
- Labor Market Information
- Dislocated Worker Re-training
- GED and literacy programs
- Assessment of technology needs (assistive technology)
- Speech and language therapy
- Rehabilitation engineering (adaptive equipment)
- Medical and psychological testing and treatment

²¹ There are multiple One-Stop Career Centers in every Region.

More than 80 percent of employment services under the Workforce Investment Act in Florida utilize Individual Training Accounts (ITAs). Using ITAs, the One-Stop Career Center system provides participants with the list of eligible providers and related performance information. The participant then chooses the program that best meets his/her needs, with payment arranged through the ITAs. Training may be provided through a contract for services in lieu of an ITA for: on-the-job training and customized training; or where there is an insufficient number of providers to meet the competitive purposes of ITAs. Contracted training may also be provided for programs offered by community-based organizations or other private agencies that serve special participant populations that face multiple barriers to employment.

< TWWIA >
Ticket to Work,
Work Incentives Improvement Act

The Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIA) creates employment options for individuals with disabilities that receive Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI) payments. Individual recipients of benefits under these programs receive an annual “ticket to work.” This ticket to work functions like a voucher, in that it allows individuals to choose among service providers for rehabilitation, case management, and job placement services. The federal TWWIA permits states to voluntarily “buy in” continued Medicaid coverage for individuals that earn too much from competitive employment to maintain their SSDI or SSI payments. However, Florida has not elected to implement this optional Medicaid buy in at this time.

Eligible Populations

Adults between the ages of 18 and 64 who receive Social Security Disability Insurance (SSDI) and/or Supplemental Security Income (SSI) by reason of disability automatically receive a Ticket-to-Work on an annual basis. Use of the Ticket-to-Work voucher, once received, is purely voluntary on the part of the SSDI or SSI recipient. Approximately 475,000 individuals in Florida (2.9 percent of the population) have received Tickets to Work.

Administering Agency

TWWIA is administered by the Social Security Administration at the federal level. In Florida the lead agency is the Department of Education, Division of Vocational Rehabilitation (DVR).

Financing

The Social Security Administration (SSA) reimburses Employment Networks for each individual who receives SSI or SSDI for each month a person with a ticket is employed. There are two methods: the Outcome Payment Method or the Milestone Payment Method. The Outcome Payment System will reimburse Employment Networks 40 percent of the Payment Calculation Base (PCB). The PCB is the national average of the SSI (\$498) and SSDI (\$840) monthly benefit for 2003. Therefore, an Employment Network could receive approximately \$196/month for each SSI and \$328/month for each SSDI recipient who uses their ticket and does not receive an SSI or SSDI payment. The total payment is limited to 60 months. Outcome payments do not have to be consecutive.

Milestone payments are slightly more complicated. The milestone payments are often used for individuals who may have more difficulty initially in maintaining their employment status. Payments are made to Employment Networks based on certain work “milestones” in that individual’s life. For instance, payment is made for the initial month

an individual is working and receives no SSI/SSDI reimbursement. The Employment Network would receive a payment for an individual who works 3 calendar months in a 12 month period. There are four milestones. Each of these milestones and the related PCB is illustrated below.

Milestone	Must occur before the first outcome payment month and is achieved when the beneficiary works	% of PCB	SSI Ticket Holder	SSDI Ticket Holder
1	1 calendar month	34%	\$167	\$279
2	3 calendar months within a 12-month period	68%	\$334	\$557
2	7 calendar months within a 12-month period	136%	\$668	\$1,114
4	12 calendar months within a 15-month period	170%	\$836	\$1,393

Support Services Covered

Beneficiaries receiving Tickets can contact one or more Employee Networks (see below) to discuss services, and once an agreement between the beneficiary and EN is reached, the two work together to develop a work plan to assist the beneficiary in reaching his or her employment goal. Employment and employment-related services are essentially the same as services available through One-Stop Centers under the Workforce Investment Act. In addition, designated employee network providers will assist SSDI and SSI recipients to calculate strategies to maintain income and Medicaid or Medicaid to the extent possible while increasing earned income through employment.

Provider

To receive the Ticket to Work, a provider has to be a certified member of the Ticket to Work Employment Network. Employment providers apply for certification in the Employment Network through MAXIMUS, Inc., a national contractor working with the Social Security Administration to implement the Ticket to Work program. In Florida, SSDI and SSI recipients holding a Ticket to Work can access certified Employment Network providers through the One Stop Career Centers or the Regional Workforce Boards.

Employment Network providers may deliver a number of employment-related services to SSDI and SSI recipients, including job readiness assessment, rehabilitation and training, job coaching, and job placement. The Employment Network provider will also assist the individual to develop an employment plan, which includes a calculation of the amount of income that can be earned through employment without losing SSDI or SSI benefits.

< *Veteran's Employment Program* >

The Department of Labor's Veterans' Employment and Training Service (VETS), through cooperative efforts with, and grants to, each state, offers employment and training services to eligible veterans through two principal programs: Disabled Veterans' Outreach Program and the Local Veteran's Employment Representatives. The Disabled Veterans' Outreach Program (DVOP) specialists develop job and training opportunities for veterans, with special emphasis on veterans with service-connected disabilities. DVOP specialists provide direct services to veterans enabling them to be competitive in the labor market. They provide outreach and offer assistance to disabled and other veterans by promoting community and employer support for employment and training opportunities, including apprenticeship and on-the-job training.

Local Veterans' Employment Representatives (LVERs) are state employees located in state employment service local offices to provide assistance to veterans by:

- Supervising the provision of all services to veterans furnished by employment service employees, including counseling, testing, and identifying training and employment opportunities;
- Monitoring job listings from federal contractors to see that eligible veterans get priority in referrals to these jobs;
- Monitoring federal department and agency vacancies listed at local state employment service offices and preliminary processing of complaints from veterans about the observance of veterans' preference by Federal employers;
- Promoting and monitoring the participation of veterans in federally-funded employment and training programs;
- Cooperating with the U.S. Department of Veterans' Affairs to identify and aid veterans who need work-specific prosthetic devices, sensory aids or other special equipment to improve their employability; and
- Contacting community leaders, employers, unions, training programs and veterans' service organizations to be sure eligible veterans get the services to which they are entitled.

Populations

Veterans may qualify for vocational educational counseling if they also qualify for VA education or education-related services. To qualify for VA vocational rehabilitation, the veteran must be determined to have an "employment handicap." VA employment specialists are stationed at many One-Stop Centers, and they can determine eligibility for VA vocational services at those locations.

Administering Agency

The Veteran's employment programs are managed and funded nationally through Veterans Affairs. In Florida these programs are administered by the State Department of Education, Division of Vocational Rehabilitation (DVR). DVR administers the Veterans employment service through the 24 Regional Workforce Boards and their networks of One-Stop Centers.

Financing

The Department of Labor provides grant funds to each state's employment service to maintain DVOP specialist positions in the state. The staffing formula and current appropriations level support about 1,400 DVOP specialists nationally. There are approximately 97 DVOP specialists in Florida. DVOP specialists are employees of the state and are generally located in state employment service offices.

Support Services Covered

The Vocational Rehabilitation and Education program offers a variety of employment services as a means to obtain suitable employment. Included are:

- Assistance in finding employment
- Job seeking skills training
- On-the-job training and apprenticeships
- Job development
- Vocational training
- One-year certification programs
- Two-year diploma programs
- Two- and four-year post secondary training programs

DVOP specialists work with employers, veterans' organizations, the Department of Veterans' Affairs and Defense, and community-based organizations to link veterans with appropriate jobs and training opportunities.

DVOP specialists serve as case managers for veterans enrolled in federally-funded job training programs such as the Department of Veterans Affairs' Vocational Rehabilitation program, and other veterans with serious disadvantages in the job market. DVOP specialists are available to those veterans and their employers to help ensure that necessary follow up services are provided to promote job retention.

Providers

DVOP specialists may be stationed at regional offices and medical or veterans' outreach centers of the Department of Veterans' Affairs, state or county veterans' service offices, One Stop Centers, community-based organizations, and military installations. To contact

a DVOP specialist, call or visit the nearest State Employment Service (sometimes known as Job Service) agency listed in the State Government section of your phone book.

< **TLP** >
Transitional Living Program for Older Homeless Youth
and
< **ILP** >
Independent Living Program

The growing concern for youth who were transitioning or leaving the foster care system and at high risk for being homeless prompted Congress to determine that many young people need long-term, supportive assistance that emergency shelter programs were not designed to provide. There are several programs that have been developed since the late 1980's to address the needs of young people, especially in foster care, who need supports for their transition to independent living.

The first program, the Transitional Living Program for Older Homeless Youth (TLP) is part of the 1988 Amendments to the Runaway and Homeless Youth Act (RHYA). The TLP was modeled after several successful demonstration projects funded in the early 1980s by the U.S. Department of Health and Human Services (HHS). These services are designed to help youth who are homeless make a successful transition to self-sufficient living. Transitional Living Program funds are to be used for the purpose of enhancing the capacities of youth-serving agencies in local communities to effectively address the service needs of homeless, older adolescents and young adults, including pregnant and parenting homeless youth. Goals of the TLP program are:

- Providing stable, safe living accommodations while a youth is homeless;
- Providing the services necessary to assist homeless youth in developing both the skills and personal characteristics needed to enable them to live independently;
- Providing education, information and counseling aimed at preventing, treating and reducing substance abuse among homeless youth;
- Providing homeless youth with appropriate referrals and access to medical and mental health treatment;
- Providing the services and referrals necessary to assist youth in preparing for and obtaining employment;
- Providing the services and referrals necessary to assist youth in preparing for and obtaining secondary, and where feasible, post-secondary education and/or vocational training; and
- Providing the services and referrals necessary to assist pregnant and parenting homeless youth with the skills and knowledge necessary to become a more effective parent and lead productive and independent lives.

The second program, the Independent Living Program is designed to help young people make the transition from foster care to self-sufficiency. This program helps participants to obtain a high school diploma, a GED or to participate in vocational training. Program funds may also be used to provide training in daily living skills, such as budgeting,

locating housing, finding a job or planning a career. Funds can be used to provide youth individual or group counseling and coordinate other social services available to the youth.

Populations

The Transitional Living Program is targeted to homeless youth ages 16–21 for up to 18 months. Transitional Living Programs are required to provide services in residential settings for at least four (4) youth and no more than twenty (20) youth.

Initially, the ILP was limited to youth aged 16 – 18 for whom foster care maintenance payments were being made under Title IV-E (“IV-E eligible”). Beginning in FY 1989, States were allowed the option to provide ILP services to non-IV-E eligible youth who were in out-of home care and/or under the responsibility of the State’s child welfare system. They also were allowed to provide follow-up services to youth for up to six months after discharge from foster care. Youth participation in ILP services has always been voluntary. At State option, the program may serve both children who are eligible to receive Federal title IV-E foster care maintenance payments and youth in foster care supported through State dollars. States may also opt to serve children beyond the age of 18, up until the age of 21.

In Florida, eligible youth between the ages of 16 and 23 can participate in the Independent Living Program. In order to apply for the Independent Living Program, the youth must meet the following criteria: be a minimum of 16 years of age; have been in the custody of the Department a minimum of six months; be employed at least part-time; be enrolled in a full-time educational program; maintain a 2.0 grade point average; have sufficient earned savings or other means to move in and pay first month's living expenses; and demonstrate abstinence from irresponsible behavior for at least six months. In addition, the youth must have approval by the district independent living coordinator. Approximately 1400 youth are served by the Independent Living Program.

Administering Agency

Congress assigned administration of the TLP to the HHS's Family and Youth Services Bureau (FYSB). The Transitional Living Program is part of FYSB's Runaway and Homeless Youth Program and is authorized by the RHYA, as amended by the Missing, Exploited, and Runaway Children Protection Act (Public Law 106-71).

The ILP was first authorized by Public Law (P.L.) 99-272 in 1986, through the addition of section 477 to Title IV-E of the Social Security Act (the Act). The Act provided funds to States for assisting youth aged 16 and older who have been or are in foster care to make the transition to becoming self-sufficient adults. In subsequent years the title of this program changed to the Chafee Foster Care Independent Living Program.

Financing

Public agencies and private non-profit agencies are eligible to receive funding for the Transitional Living Program and the Independent Living Program. In FY 2003 HHS awarded \$7.9 million for new TLP program. Congress authorized \$27.8 million in continuation funds for current TLP grantees. TLP recipients are required to match these federal grant funds with 10 percent state, local or other non-federal funds. The non-federal funds may be a cash or in-kind contribution.

The Independent Living Program is funded at \$200 million. Funds are currently allotted among the States based on a formula tied to the number of children in the State who were receiving title IV-E foster care maintenance payments in previous years. In FY 2003 Florida received approximately \$8 million in federal funding for the Independent Living Program. An additional \$2 million in state funds were available to match these federal funds.

Services Provided

TLP grantees are required to provide youth with stable, safe living accommodations and services that help them develop the skills necessary to move to independence. Living accommodations may be host family homes, group homes, or "supervised apartments." (Supervised apartments are either agency-owned apartment buildings or "scattered-site" apartments, which are single-occupancy apartments rented directly by young people with support from the agency.) TLP grantees are required to offer the following services, either directly or by referral:

- Safe, stable living accommodations
- Basic life-skill building, including consumer education and instruction in budgeting, using credit, housekeeping, menu planning, and food preparation
- Interpersonal skill building, including enhancing young people's abilities to establish positive relationships with peers and adults, make decisions, and manage stress
- Educational opportunities, such as GED preparation, postsecondary training, or vocational education
- Assistance in job preparation and attainment, such as career counseling and job placement
- Education, information, and counseling to prevent, treat, and reduce substance abuse
- Mental health care, including individual and group counseling
- Physical health care, including routine physicals, health assessments, and emergency treatment

The program requirements for the Independent Living Program are broad, allowing states to have great flexibility to design services that meet the wide range of needs and circumstances of the youth in care. Further, States can tailor programs to respond to local

conditions and to complement other ongoing youth initiatives. Activities under the ILP that a state may choose to offer include, but are not limited to:

- **Education and vocational services**—including high school/GED academic support, vocational training, post-secondary educational support, driver education, and purchase of educational resources;
- **Career planning and employment services**—including job search and preparation, job maintenance, and purchase of career resources;
- **Housing services**—including locating and maintaining housing, home management, supervised living, and purchase of home supplies;
- **Money management services**—including budgeting and money management skills;
- **Health care services**—including personal care, medical and dental care education, and sex education;
- **Mental health and well-being support services**—including individual and group counseling, support groups, substance abuse prevention/intervention services, and teen parenting classes;
- **Youth involvement activities**—including youth conferences, youth advisory councils, newsletters, cultural awareness programs, recreation, mentoring, and other general youth development/involvement activities; and
- **Support services**—including outreach/recruitment, stipends/incentives, transportation, legal services, and referrals and linkages to community resources.

Providers

DCF has a statewide network of Independent Living Coordinators (ILC) throughout the state. Many of these independent living coordinators are DCF employees. In addition, there are five community-based independent living programs that are contracted to provide ILC.

< *State General Revenue Funds* >

State general revenue funds are used to provide community, tenancy and employment supports to individuals who are in supportive housing. These funds are used for many purposes. As indicated throughout this report, state general revenue funds are often used as matching funds for federal funding for Medicaid, block grants and various programs for youth who are leaving foster care. In addition state general revenue funds are generally used to purchase services for individuals that have very low incomes and do not have insurance through a private or public insurer (e.g., Medicaid). State funds are also used to purchase supports for these individuals and Medicaid recipients when they are not a covered Medicaid service (e.g., supported employment, crisis services, etc.).

Eligible Populations

There are numerous populations that are eligible to participate in DCF-funded services. Most of the eligibility criteria for the populations included in this report are identical to the eligible populations for the various block grants, the home and community-based services waiver, and Title IV-E for children in foster care. In some instances, DCF determines eligibility for receiving state general revenue fund services. In other instances, a local service provider is responsible for determining whether the individual meets the DCF criteria. This is especially true for individuals with a substance abuse disorder who seek and receive treatment from various substance abuse providers.

Administering Agency

Most of the state general revenues for community supports for the populations in this report are the purview of the Department of Children and Families. It is difficult for the Department to specifically identify the total funds that are expended on various community, employment and tenancy support services.

Covered Services

Services purchased with general revenue funds mirror those discussed in the Medicaid, Block Grant, PATH, Independent and Transitional Living Programs and the various employment programs. For mental health and substance abuse services, the covered services and their description are exactly the same as the block grant definitions. For developmental disability services, the service descriptions parallel the description in the three Home and Community-Based Waivers. For older youth transitioning from or leaving the foster care system, the services purchased using general revenue funds are identical to services identified in Florida's Title IV-E plan.

Providers

Unlike Medicaid, providers that receive general revenue funding are not required to be certified. They must have a contract with the Department of Children and Families or

Department of Vocational Rehabilitation. The qualifications and requirements of these providers are explicitly stated in their contractual arrangement with DCF and are often based on a past procurement. Therefore, there are not consistent criteria across DCF Offices and DVR for providers that receive state general revenue funds.

Section 3: Issues

Florida's Strategic Plan for Supportive Housing for Persons with Mental Illness cited a number of issues that best summarize the barriers to enhancing supports and services for individuals in supportive housing. For instance, the lack of choice in housing options coupled with the lack of state funding available for supportive housing services has created significant barriers to permanent housing access for persons who are homeless or at risk of being homeless. State and federal budget shortfalls will continue to impact the availability of funds for services and supports. The eligibility requirements to access housing and services create barriers. In addition, the various agencies lack comprehensive planning data to advocate for additional housing and services. Reductions or restrictions on Medicaid, TANF and other federal funding streams may hinder the expansion of services.

Funding

In general, the public community mental health, substance abuse and developmental disability service systems in Florida are under funded. This is supported in recent testimony provided by DCF. In Fall 2001, the Department of Children and Families projected that an additional \$206.4 million was needed to address the mental health needs of current and new adult consumers with serious mental illnesses. Approximately \$131 million was needed to serve the needs of current adult consumers; \$11.5 million for individuals with community forensic involvement and another \$63.7 million for new consumers who are not enrolled in the mental health system who need mental health services.²² DCF also estimated an additional \$154.9 million was needed to provide a model package for the estimated 50,000 children with serious emotional disturbances. Almost 5,000 of these children would be new to the mental health system. The total funding needed for both children and adults with significant mental health needs is \$361.3 million.

Florida ranks second lowest in its Medicaid community mental health expenditures per capita, expending 15 percent less than the peer state with the next lowest per capita expenditures – Georgia. However, Georgia has launched a revenue maximization initiative that would increase its overall Medicaid expenditures for community mental health services by 25 percent in the next two years.²³ Medicaid substance abuse expenditures per capita in Florida were the third lowest among its peer states. For example, expenditures were 60 percent lower than Georgia and 75 percent lower than

²² Response to the Senate Committee on Appropriations, Department of Children and Families, November 2001.

²³ Response to the Senate Committee on Appropriations, Department of Children and Families, November 2001.

Michigan. Medicaid developmental disability waiver services expenditures per capita were also very low compared to peer states. They were the third lowest in the CMS southeast region—10 to 50 percent lower than these states. Florida spending for developmental disability services under the waiver was about 18 percent of the state of New York's expenditures.²⁴ Rates for certain developmental services are low. The rate paid for in-home supports is much lower than rates for other services in the Waiver. These lower rates are directly contributing to high staff turnover, shift coverage and the quality of care.

A review of the Florida Medicaid mental health and substance abuse program indicate that rates for certain services are significantly lower than similar services provided in peer states. Most noteworthy is the current rate for basic living skills training and social rehabilitation and counseling that could be used to support individuals in supportive housing. In some instances, Florida was reimbursing providers 40-50 percent less than similar services under other states' Medicaid program. State officials have acknowledged these lower rates. A Summary of AHCA's 1999/2000 Legislative Budget Request states that the low reimbursement rates make it difficult for the provider to recruit and retain high quality staff.

There have been several recent legislative initiatives that will or may have an impact on mental health and substance abuse services for Medicaid recipients. SB 2404 requires DCF to implement a Medicaid behavioral health managed care initiative statewide by FY 2007 to provide comprehensive inpatient and outpatient mental health and substance abuse services through a capitated prepaid arrangement to Medicaid recipients. AHCA did not implement a prepaid demonstration in some areas of the state because the historical fee-for-service billings are too low. In addition, there was a decrease in Medicaid reimbursements per recipient for several years.²⁵ Developing a capitation rate with historically low and declining fee-for-service reimbursements may not provide a sufficient capitation rate to ensure adequate access and quality. Moreover, potential federal Medicaid reimbursement will be lost if inadequate capitation rates are set based on the currently underdeveloped Medicaid services system.

There are 14,000 individuals with developmental disabilities that are on the waiting list for home and community-based waivers. The bulk of these individuals are older adults (over the age of 50) living with their elderly parents. Advocates indicate there is a huge crisis looming—as these parents become more frail and die, there may not be enough housing and support options. Very little is being done to prepare these families for this transition. Even if there were additional waiver services, DCF prioritizes admission to the program based on crisis rather than first come first serve.

Funds for community support and employment services are very limited and often face competing priorities. For example, federal grants for Welfare-to-Work were capped, and

²⁴ Policies and Resources Related to Waiting Lists of Persons with Mental Retardation and Related Developmental Disabilities, Research and Training Center on Community Living Institute on Community Integration (UAP) College of Education and Human Development University of Minnesota, 2002.

²⁵ Florida Advocacy Center Report

most states have spent whatever funds were originally appropriated for this program.²⁶ In TANF, funds may be used for employment and employment-related services, but only to the extent that funds are not necessary to make basic income support payments. When TANF enrollment increased, fewer dollars could be available at the state level for employment, childcare, etc. For Workforce Investment Act funds, there are many competing priorities, including re-training for workers displaced by company closings, etc. There is no special priority or targeting of the funds for people with disabilities who are homeless or at risk of homelessness.

The Substance Abuse and Mental Health (SAMH) program within Temporary Assistance for Needy Families (TANF) that provides screening, assessment, case management and treatment services to persons is also being reduced. The SAMH TANF program has been funded primarily by federal TANF funds for FY 2002-2003. Almost 67 percent of these funds (\$16.6 M of the \$24.6 M) is non-recurring federal funding that will need to be supplanted with state general revenue funds.

Funding from the Mental Health Block Grant and the Substance Abuse Prevention and Treatment Block Grant is finite. As indicated in the previous section, the block grant is allocated to a state based on a federal formula. Florida has seen modest increases in these block grants over the past several years due to increased population and other factors. However, there are various competing requirements and priorities for spending a state's block grant. For instance the SAPT Block Grant has various set-asides for prevention and populations that may not need supportive housing.

With the exception of certain TANF-related activities, employment services funded by federal and state governments are not entitlements. That means that individuals can meet all the income and unemployment criteria necessary to access employment services, and still not be able to receive them. Given the scarcity of publicly funded employment services, it may be difficult to get local employment service providers to assign a priority to adults with disabilities who are homeless or at risk of homelessness.²⁷ Because employment programs are not entitlements, the funding sources are less proscriptive about how the programs are implemented, which employment services are delivered to whom, and what priority is given to the various groups of applicants competing for the funds. Providers, case managers and advocates working with homeless people with disabilities may experience a high degree of variation among the various one-stop centers and other employment providers.

²⁶ See footnote 1 re: rescission of WtW funds.

²⁷ Individuals do have certain non-discrimination and appeal rights under DVR in Florida. There is also an employment Ombudsman, who can be reached at (866) 515-3692.

Federal Matching Funds

The State of Florida does not have an effective federal matching funds strategy. Florida ranks 47th in the country for drawing down federal funds for various health and human services programs.²⁸ It is estimated that Florida did not pursue approximately \$900 million in federal matching funds due to the lack of state and local matching funds.²⁹

State Medicaid match for most substance abuse and mental health community support services in Florida is the responsibility of AHCA and not of DCF. DCF is responsible for state matching funds for mental health targeted case management, intensive case management services and assertive community treatment. The SAMH within DCF program has expressed concern over transferring matching state funds from DCF to AHCA to draw down additional Federal Medicaid Assistance Percentages (FMAP) for substance abuse and mental health services for Medicaid recipients. This transfer could result in an erosion of the SAMH program budget for non-Medicaid individuals and services and does not allow budget predictability. If utilization of these services increases, DCF must transfer more funds. Florida's arrangement for meeting the federal match requirement has already provided disincentives for DCF to pursue case management services through the Medicaid Targeted Case Management program, or additional services covered under the Community Mental Health Services program.

In addition, counties provide a significant amount of local funds for various substance abuse and mental health treatment and support services including drug courts and the Family Safety Initiative. This local money could be used as match for FMAP for mental health and substance abuse services. However, the counties share DCF's concerns regarding transferring match from their budgets to AHCA.

In 2003, Senate Bill (SB) 1454, the Local Funding Revenue Maximization Act, was passed by the Florida Legislature. The Act authorized the use of certified local funding for federal matching programs for local preventive services and child development programs. Specifically, the public revenue funds of local subdivisions (e.g., counties, municipalities) could be used to as match to draw down federal dollars. Participation by local subdivisions in the federal matching process for these services is voluntary.

In addition to public tax generated revenues, funds donated by the United Way, community foundations to counties and municipalities could also be used for federal match. This legislation provides some safeguards that local monies will be used to support and not supplant state matching funds. The state must also reimburse local subdivisions within 30 days of receiving federal reimbursement.

It should be noted that local subdivisions already provide local match for Medicaid reimbursement for nursing homes. These subdivisions could choose to provide match for

²⁸ Private Sector Funding of Health and Human Services: Implications for Strategies to Increase Revenue Maximization, Donors Forum of Southern Florida.

²⁹ An Overview of SB 1454 Local Funding Revenue Maximization Act, Unites Way of Florida.

various other health and human services programs. SB 1454 provides a much needed framework for how state agencies and local subdivisions can work together to best maximize revenues while protecting the local subdivisions from significant financial liability.

There are some counties that are actively pursuing the implementation of SB 1454 (Miami). These counties have developed revenue maximization strategies for the next several years that take advantage of the provision of this legislation. Some counties have indicated their interest in pursuing revenue maximization opportunities; however, need additional information regarding the administrative logistics of using county dollars for federal match. In addition, there is still some uncertainty at the state level as to whether the state can guarantee that the county of origin will receive a return on its investment. Specifically, the DCF has indicated that it may not be able to return funds on a dollar-for-dollar basis for some federal programs. Without this guarantee, counties will be very reluctant to develop and implement revenue maximization efforts.

Service Coverage Issues

Although the current Medicaid State plan for mental health services include a mix of clinical and rehabilitative services, the majority of services provided to individuals with either a serious mental illness or substance abuse disorder represent a more medical and clinical approach rather than rehabilitative and skill building services. Some of the services in the plan reinforce outdated views of what works for these populations, especially for adults with a serious mental illness. These views include that adults with serious mental illness can benefit from traditional outpatient therapies, multi-modal assessments and day treatment programs that focus more on treatment and clinical oversight than meaningful social, rehabilitative and vocational programs.

The Florida Medicaid community mental health and substance abuse program includes three services that focus on skill building for adults: basic living skills training; social rehabilitation and counseling; and rehabilitative day treatment. Although the first two services offer a very flexible community support benefit they are not available statewide. In addition, stakeholders indicated that the model for rehabilitative day treatment services is not clear and do not always enhance an individual's recovery with incentives to provide care in facilities versus an individual's home.

In addition, the definition Florida uses for Targeted Case Management is also outdated. The current definition is "assist recipients in gaining access to necessary medical, social, educational, and other services." This definition reflects a "broker" model of case management versus a more rehabilitative or intensive case management approach, which is often more effective for adults with serious mental illnesses and children with serious emotional disturbances. The array of services does not include other recovery-based services such as psychosocial rehabilitation (e.g., clubhouses), community support (a hybrid of case management, supportive therapy and skill building) and peer supports (services provided by people with psychiatric disabilities).

The current Medicaid home and community-based waiver for supportive living only serves six individuals. Three years ago, DCF received significant funding to expand the number of slots in the various waivers. DCF created more small group residential settings (three to four beds) rather than developing supportive housing opportunities for these individuals.

Individuals with developmental disabilities, especially those transitioning from special education to work have little access to supported employment services. Many of these individuals are not considered “in crisis” and, therefore, can not access supported employment through the Medicaid Home and Community-Based Waivers. The Department of Vocational Rehabilitation will provide short-term training and employment supports to these individuals. However, these supports are time limited.

There is limited coverage for community substance abuse services under Florida’s Medicaid program. Medicaid targeted case management is not a covered service for individuals with a primary diagnosis of substance abuse that could otherwise allow for the necessary aftercare services. The Medicaid substance abuse benefit does not specifically include several key services that promote recovery and would support individuals in supportive housing. Effective services not included in the current Medicaid benefit are community support, various aftercare services and crisis services. These services are funded primarily through federal block grant, state general revenue, local funds, and third-party payers.

Adding these services to the State plan would require the State to provide the Medicaid matching funds. Other states have obtained new match funds by either shifting state dollars from current state-only funded services to newer services, and/or adding new state dollars to finance some of these newer services. Given the current level of State funding for Medicaid community mental health services, however, it may be difficult for the State to develop recovery-based services solely through efforts to refinance current services.

Most employment programs are targeted for adults as opposed to youth under the age of 18. Thus, youth transitioning from special education and/or from foster care, and school age high school dropouts, have a more difficult time accessing employment related services. These groups are among those at high risk for homelessness, and for whom steady employment could be an important key to permanent housing. For people with disabilities, particularly those with very low incomes, gainful employment often means reduction or loss of benefits such as SSI and Medicaid. The loss of these benefits is reported to be the single greatest barrier to substantial gainful employment on the part of adults with disabilities. The Social Security and SSI programs both have provisions that allow beneficiaries to protect benefits while increasing income from employment and moving towards independence. However, these programs are very complicated, and professional assistance is frequently necessary to establish a workable plan for becoming employed and also protecting necessary benefits.

Florida is not a Medicaid “Buy-In” state, so people losing their SSI as a result of gainful employment cannot maintain Medicaid coverage in most cases. In FY 2001, legislation

was passed to allow the state to develop a Medicaid “buy-in” program. However, due to the events of 9/11 the legislation was repealed. The Florida Advocacy Center is leading an effort to revisit a Buy-In program. A recent report, Freedom to Work 2003,³⁰ has been developed, which outlines the proposed Buy-In program for the state of Florida.

Most employment programs provide a fixed amount of time and level of services assisting individuals to move from unemployment or under-employment to full employment. Once employed, there is little available in the way of on-the-job supports and other follow-along services. People with disabilities such as co-occurring mental illness and substance abuse, including those who are homeless or at risk of homelessness, may not fit well into an employment service model. These models often have rigid employment criteria, fixed time frames, and minimal follow-along supports.

Tenancy support services have frequently been funded with general fund dollars or with HUD Supportive Housing Program funds from McKinney/Vento grants. HUD’s policy to increase the proportion of McKinney/Vento dollars spent on permanent housing, in concert with limited availability of state general fund dollars in Florida, creates pressure to find new ways to organize and fund tenancy support services. As noted in the Medicaid section of this report, tenancy supports are not contained within a clear or discrete set of service definitions, and this complicates the task of bringing services and supports together around individuals or groups of individuals to foster successful tenancy.

In project-based and larger scale supportive housing developments, on-site staff employed by the supportive housing sponsor frequently carries out tenancy support services and functions. In many cases neither the housing sponsoring agency nor the housing site staff meet qualifications for Medicaid reimbursement. This has proven to be a major barrier to obtaining Medicaid reimbursement for tenancy support services. Thus, relying on the staff of the housing sponsor or homeless service provider to deliver tenancy support services could reduce the potential to receive Medicaid reimbursements for otherwise eligible recipients.

Service Access

In some districts, it was reported that there may be few certified Medicaid community mental health, substance abuse and developmental disabilities service providers. Where they do exist, these agencies may not provide the full array of services needed by the individual or may not have enough capacity to meet the demands of their community. In these instances, individuals and families reported seeking services in adjacent districts. Often these services are a significant distance from an individual’s home. Although Medicaid will pay for transportation, some stakeholders were not aware of its availability. Therefore, individuals and family members perceive they can not get to the service, even if it is available.

³⁰ Freedom To Work 2003, An Update to the 2000 Medicaid “Buy-In” Program: A Cost and Feasibility Study, Advocacy Center for Individuals with Disabilities.

Access problems are more than “anecdotal.” This lack of services is reflected in various plans by the Department of Children and Families. For example, one of the District Plans states that although the adult mental health services have been a priority area for funding and service development, the full continuum of State recommended mental health services were not available in *any* communities in that District. The plan also states that the lack of community services has increased the need for inpatient psychiatric services.

Access to services is also an issue for individuals with developmental disabilities. In FY 2000, DCF identified provider development as an issue. In FY 2001, the districts completed a district needs assessment. Each district was to develop a written plan to increase provider capacity in those areas where there was a need. It is unclear the extent to which this assessment occurred and whether the network was enhanced.

The Advocacy Center’s findings also indicate that there are still waiting lists for Medicaid mental health, substance abuse and developmental disability services. Waiting lists were defined as individuals who have an identified service need who are not getting a service and/or are receiving a “substitute” service that does not address the goals identified in their service plan. In some instances, individuals waited up to four weeks for an initial assessment for treatment planning purposes. District Plans have also indicated that the development of community-based services has not met the demand for such services and that waiting lists are continuing to grow. For individuals with developmental disabilities, the current waiting list for the Medicaid Home and Community-Based Waiver was approximately 14,000 individuals.

Stakeholders also indicated that the original intention of the rehabilitation option was to redesign and refinance services purchased with general revenue funds. These individuals indicated that the refinancing policy was never fully implemented—federal funds supplanted, not supported, State general revenue dollars. An additional concern identified by stakeholders was that savings from prior authorization efforts on inpatient psychiatric hospital stays were not redirected back to community services. The net effect was an overall loss of funding for mental health and substance abuse services to individuals who are Medicaid eligible.

Lower rates have various negative consequences for access to services. Lower rates may offer incentives for providers to deliver the service in a more structured clinic-based setting rather than an individual’s or family’s natural environment. Clinic-based settings provide greater predictability in productivity and ensure some level of consistent revenue. Providers can “double schedule” individuals to compensate for individuals who are “no shows.” Providers can predict individuals’ participation on structured programs based on historical attendance. Services provided in an individual’s home, school, and other settings could affect costs. Staff productivity expectations are lower, although efficacy is usually higher.

Individuals with co-occurring disorders often receive no treatment.³¹ If these individuals do receive treatment, only one disorder is addressed, rather than treating both types of disorders at the same time, in the same setting. The Florida State Mental Health and Substance Abuse Plan indicated that these populations have been treated through parallel systems, receiving services from mental health providers to address mental health symptoms and separately receiving services from substance abuse providers for alcohol and other drug problems. Florida requires individual licenses for each service in Substance Abuse programs. Therefore, an organization that provides multiple substance abuse services will need to apply for and obtain several licenses. In most instances, providers find this process duplicative and cumbersome. Mental health programs are not individually licensed in this way. Mental health organizations, therefore, are reluctant to provide substance abuse services to individuals with both substance abuse problems and mental illnesses.

A recent survey of transitional living programs found that 78 percent of young people participating in TLP programs were employed either part- or full-time, 74 percent of youth were discharged to stable housing at the completion of the program, and, six months after completing participation in the program, 78 percent remained free of all direct government aid.³²

Research tells us that the Independent Living Program's services can and do make a difference in the lives of young people. A 1990 study found that providing more comprehensive services, including teaching a combination of skills—money management, consumer and credit management, education and employment skills—helped youth to achieve better outcomes. Improvements in outcomes were seen in increased high school graduation rates, greater ability to maintain a job for at least a year, accessing appropriate health services, avoiding young parenthood and decreased dependence on public assistance programs.

³¹ SAMHSA (1997) Improving services for individuals at risk of, or with, co-occurring substance abuse-related and mental health disorder: A SAMHSA conference report and a national strategy.

³² Ibid 5)

Section IV: Recommendations

The previous section highlights a complicated set of issues that cannot be addressed by one single strategy. Issues regarding access to services and eligibility cannot be easily addressed by minor policy changes or additional state funding. Federal block grant funding is finite and is dependent on several factors that are not within the state's control. The most pressing issue is the lack of availability of new state revenues that can be used for community, tenancy and employments support. The FY 2005 budget proposal by the Governor advocated for reforms to restrain the growth in the Medicaid budget. The proposed budget will increase by approximately \$1.4 billion. More than three-fourths of this increase is for rising expenditures in the Medicaid program. Funding for federal programs is not expected to increase significantly. The President's FY 2005 budget was released in February. All federal agencies were asked to develop a budget for FY 2005 at FY 2004 levels.

The following recommendations were developed by taking into account the complexities of each mainstream funding source and the current federal and state fiscal climate. The recommendations also took into account several recent reports by the Department of Children and Families, the Homeless Policy Academy and the Florida Advocacy Center. These reports set forth various recommendations regarding supportive housing and services and supports that were needed by individuals with disabilities. The following recommendations build upon these reports and set forth some additional strategies to be pursued by the Florida Supportive Housing Coalition with DCF and the Agency for Health Care Administration. These recommendations are grouped into three strategic areas:

- Changes to current federal and state expenditures that will provide better access to community, employment and tenancy supports. These changes include shifting funds, using state and local monies to leverage additional Medicaid funds and changing current service definition and requirements to provide more flexible supports for individuals that were the focus of this report.
- Action steps that could be considered if any new state and/or federal funds were available. Such steps could include very modest changes in program eligibility and adding some meaningful services and supports.
- Strategies the Florida Supportive Housing Coalition should pursue to gain better access to services and supports that are needed for individuals in supportive housing. These strategies focus on the feasibility and prudence of the Coalition members enhancing their role as providers of supports and services to individuals covered in this report.

There are several recommendations that could be implemented that would enhance the community, employment and tenancy support services with little or no new additional state funding.

- ***Recommendation #1: Revising Current Medicaid Community Services.***

The Advocacy Center Report recommended several changes to the Medicaid program that would provide a more flexible case management and skill building model for individuals with mental illnesses, individuals with substance abuse and individuals with co-occurring disorders.³³ This more flexible model is called community support. States that have included community support in their Medicaid state plan have replaced their previous definitions of individual skill building and targeted case management with this broader definition of community support. Best practice and literature indicate that adults with serious mental illnesses and adults with addictive diseases do better with a case management model that is more service delivery oriented than a “broker” model of case management (although at certain times they may need an individual to act as a broker). Specifically, individuals are able to learn the skills they need to negotiate human services systems and community services rather than having a case manager perform these activities on their behalf. They also have “one” individual who is responsible for providing brokerage services and skill-building services, rather than having separate case managers for supported housing, supported employment or supported living. Community support services can be delivered in various community settings including home or work. Allowable community support activities include:

- Assistance and support in-vivo in crisis situations;
- Individual interventions, which develop interpersonal and community coping skills, including adaptation to home, school and work environments;
- Symptom monitoring and self-management of symptoms, which shall have as its objective the identification and minimization of the negative effects of psychiatric symptoms that interfere with the individual’s daily living, financial management, personal development, or school or work performance;
- Assistance to persons served to increase social support skills that ameliorate life stresses resulting from a person’s disability;
- Coordination to gain access to necessary rehabilitative and medical services, as well as coordination of services in the individual’s service plan;

³³ Blueprint for Reforming and Enriching Florida’s Medicaid Services, the Advocacy Center for Individuals with Disabilities, April, 2002.

- Relapse prevention strategies and aftercare services;
- Ensuring availability 24 hours a day, 7 days a week for individuals who are in crisis, but may not need mobile crisis or crisis residential services.

- ***Recommendation #2: Identify Acceptable Options for State and Local Match.***

Some mental health, substance abuse and developmental services that are provided to individuals in supportive housing are financed through state and/or local general revenue. This includes treatment and support services provided by mental health case managers, support workers, substance abuse Family Intervention Specialists, and TANF staff that provide case management. As indicated in the previous section, both DCF and counties are reluctant to use state and local funds for match especially if they have to transfer matching funds to another state agency. The current process of transferring funds to AHCA is overly conservative and will not be acceptable to either counties or DCF.

SB 1454 does provide a vehicle for state agencies and local subdivisions to enter into agreements for enhancing federal funds. SB 1454 provides sufficient safeguards and protocols for ensuring match is used to support and not supplant state funds (with the exception of Medicaid). Therefore, state matching funds for various children's programs, such as the Transitional Living and Independent Living Program, could not be supplanted by local match.

However, for other programs, including Medicaid, it allows the counties to receive a significant return on their match investment. This return ranges from 50-58 percent depending on the federal program.

However, the current legislation does not go far enough. SB 1454 should be amended to include other program areas for individuals who need mental health, developmental disabilities and substance abuse services necessary to support them in supportive housing. The Florida Supportive Housing Coalition and other human services organizations should work collaboratively to amend this legislation. The FSHC should also enlist the support of the various foundations that provide funding for local health and human services initiative. These foundations were very supportive of SB 1454. In 2001 they performed an analysis of their grants to localities and identified approximately \$8 million in qualified federal reimbursement for Medicaid, TANF and Title IV-E (foster care). These foundations represent only a small amount of local funds available for health and human services.

In addition, the FSHC should support an ongoing effort to provide training and technical assistance to counties regarding the implementation of SB 1454. As indicated earlier, county officials may be interested in providing local match for various federal programs but need specific information on the administrative and financial logistics related to matching funding. FSHC should work with DCF and

local counties to clarify whether federal match can be specifically returned to the county of origin for some federal programs (e.g., TANF).

- ***Recommendation #3: Redirect Federal Block Grant Funds.***

The current Substance Abuse Prevention and Treatment Block Grant and the Mental Health Block Grant expenditures could be redirected from residential services to treatment and supports for individuals with a substance abuse disorder. DCF currently uses these funds to purchase treatment, supports and room and board for individuals in group and larger residential settings. While this approach may be successful for a short period of time (30 – 60 days), it is more efficacious to provide these individuals with treatments and services in supportive housing. The FSHC should meet with DCF to discuss how to orchestrate this transition. Although shifting money may promote budget neutrality, there can be adverse political and programmatic consequences in shifting funds.

- ***Recommendation #4: Require Housing Supports in Medicaid Managed Care Contracts.***

The Governor’s FY 2005 budget clearly supports the direction of SB 2404 directing AHCA and DCF to implement a behavioral health managed care initiative statewide by FY 2007 for Medicaid recipients. Current Medicaid managed care initiatives encourage, but do not require, mental health and substance abuse community support services specifically to individuals in supportive housing. Rather, a managed care plan that submits a bid that includes these these support services to individuals in supported housing may be awarded a better score on their proposals. The FSHC should request that AHCA require that housing supports be a mandated service in any future procurement. The benefits of permanent housing to these populations have been well documented. These managed care plans must also understand their responsibility for the supports—local housing providers can offer the “housing” component. However, it will be important that this brokerage between the housing and service providers occur.

- ***Recommendation #5: Target PATH Funds for Tenancy Support Services.***

Florida grants PATH funds to 12 geographically dispersed agencies. PATH funds can be used very flexibly, both in terms of the homeless individuals served and in terms of the specific services delivered. Thus, PATH-funded staff are ideally suited to function as the core element of a tenancy support team or other related mechanism to foster housing search and successful tenancy. Such PATH staff could function as the case manager for homeless individuals to facilitate benefits acquisition and to assist with housing related issues pending establishment of eligibility for other services. This staff could also remain as part of a team assisting previously homeless individuals to be successful in independent

supportive housing. Finally, the PATH staff could remain as the primary source of service for individuals unable to establish eligibility for other services.

- ***Recommendation #6: Implement Presumptive Eligibility for Medicaid.***

Work with AHCA and other state officials to implement presumptive eligibility for Medicaid for certain qualifying adults with disabilities. This strategy could facilitate access to many of the services and supports necessary to move expeditiously from homelessness to independent supportive housing. This strategy could also result in Florida earning more Federal Fair Participation (FFP) for the early stages of service delivery pending SSI or Medicaid disability adjudication.

- ***Recommendation #7: Enhance Benefits Acquisition.***

Implement strategies to facilitate benefits acquisition on the part of homeless adults. Successful strategies used in other states include: (a) out stationing eligibility workers at shelters or other homeless sites to process applications; (b) accessing the online application process (Florida already has an online application) at shelters; (c) developing agreements with local Social Security Administration and Veterans Affairs offices to have staff available on site to shelters or other sites to facilitate applications for SSI and Veteran's benefits; and (d) training shelter staff and associated case managers in relevant strategies for benefits acquisition, including documentation for disability status, obtaining verification of Veteran status, etc.

In addition, the Florida Supportive Housing Coalition should support the recent proposal by the Advocacy Center with Disabilities. The major components of the plan would allow individuals to "buy in" to the Medicaid program if their countable income was up to 250 percent of the federal poverty level, exclude any retirement amount recognized by the IRS, raise the cash asset requirement from \$2,000 to \$9,000. Participants whose income exceeded 100 percent of the federal poverty level would be charged a monthly premium.

- ***Recommendation 8: Enhance Staff Competence Regarding Housing Supports.***

All providers of case management should be reasonably competent in housing related issues. Just as most providers of services to adults with serious mental illness should be dually competent in some aspects of substance abuse treatment, most providers should be dually competent in housing as well as in their service specialty. In Florida, this means that targeted case managers, members on intensive case management and community support teams, and members of FACT teams should have some basic knowledge of supportive housing principles, housing affordability strategies, resources, fair housing and ADA reasonable accommodation practices, and tenant-landlord issues. Every year Florida sets aside a portion of its Federal block grant and PATH funds for administration and

training related to these programs. It is recommended that housing and tenancy support strategies be made a priority for these training activities.

Strategic Area Two: Advocating for New Resources

The recommendations set forth in the first strategic area can provide some positive changes to enhance access to community, employment and tenancy supports. However, these recommendations do not produce significant systemic change. The FSHC must advocate collaboratively with other supportive housing advocates, organizations that support individuals with disabilities and provider trade associations to obtain funding for additional services. If additional funding is procured, there are several strategies that would greatly enhance services and supports for individuals discussed in this report.

- ***Recommendation #9: Expand Existing and Develop New Medicaid Waivers.***

Priority should be given to the 14,000+ individuals with developmental disabilities on the waiting list for home and community-based waivers. The Developmental Disabilities Services Program's future plans for new Waivers will rely heavily on new supported housing opportunities for these individuals. In addition, this will offer the greatest leverage for federal funds through the Medicaid program. For FY 2005, Governor Bush has recommended \$24.3 million in additional funding for the Supported Living Waiver next fiscal year to serve an additional 1,740 individuals.

FSHC should recommend that AHCA submit a Medicaid Waiver under the Health Insurance Flexibility and Accountability (HIFA) Act to obtain coverage for individuals that are in supportive housing who are below 150 percent of the federal poverty level. Under the HIFA Waiver a state can request Medicaid coverage for individuals who are not traditionally covered under Medicaid such as childless adults who do not qualify for SSI or SSDI. In addition, the state may limit the services offered to these individuals to basic health and support services. Several states have been granted HIFA waivers for low-income single individuals. Many of these states cover basic health and behavioral health services.

- ***Recommendation #10: Allow Peer Supports Under Medicaid.***

Peer Supports provide an opportunity for consumers to direct their own recovery and advocacy process. Peer specialists, who are individuals that are successful in their recovery efforts, work with individuals to teach and support each other in the acquisition and exercise of skills needed for management of symptoms. They also assist these individuals in using natural resources within the community rather than relying on traditional government funded services. Peer specialists promote socialization, recovery, self-sufficiency, self-advocacy, the development of natural supports, and maintaining those skills learned in other support services. Peer specialists are used in a variety of states and are a critical component of the

Florida Assertive Community Treatment teams. Comparisons in salaries and reimbursement rates indicate that peer specialists cost less than traditional mental health or substance abuse professional staff.

- ***Recommendation 11: Revise Rates for Critical Medicaid Services.***

Florida is reimbursing Medicaid mental health and substance abuse providers at 40 percent of rates paid for similar services covered under other states' Medicaid programs. Services that would benefit persons in supportive housing the most, basic living skills training and social rehabilitation and counseling are reimbursed at 20-60 percent lower than other states (with the exception of Alabama). As indicated previously, these rates affect access to services and no doubt raise questions about the quality of care agencies can offer when they receive such low reimbursement. Rates for these and other services should be reviewed and adjusted to remove reimbursement related disincentives that limit access to care.

Strategic Area Three: Role of Supportive Housing Providers

As indicated in the issues section, there is a growing tension between housing providers and agencies that receive mainstream funding to provide services and supports. The relationship between agencies that offer affordable housing and human services providers is often fraught with frustration and competition. Supportive housing providers are often frustrated with the lack of cooperation from agencies that provide services to individuals in supportive housing. Supportive housing providers often cite they are not involved or do not have knowledge of the individual's service plan.

Supportive housing providers indicate that human service agencies do not respond to their referrals in a timely manner. In addition, the human service agency may place the individual on a wait list or cannot provide the services necessary to the person in supportive housing. In addition supportive housing agencies indicate that human service agencies do not provide supports that promote recovery and self sufficiency. Human services case managers may have too many individuals on their caseloads having little time to teach and mentor skills.

Providers of supportive housing are finding themselves in a dilemma: whether to develop programs that offer the necessary supports to individuals or develop new strategies to enlist the cooperation of human service providers.

- ***Recommendation #12: Continue Cooperative Efforts with Agencies Providing Community and Tenancy Supports.***

The start up costs for developing programs that provide supports and services to sustain an individual in supportive housing is daunting. Agencies have to recruit and hire staff, seek and obtain licenses and locate adequate space for new programs. DCF, AHCA and other state agencies do not generally pay for start up costs. In addition, it is too challenging for these providers to qualify as Medicaid providers.

Many federal funding streams are not a realistic option for new providers in Florida. DCF has a moratorium on contracts with new providers. Medicaid rates for critical services are extremely low and barely pay for staff salaries and overhead. Program and operational start-up costs cannot be recouped with the current rate structure.

To address these barriers, supportive housing providers could operate under the aegis of an already certified Medicaid provider. This can be accomplished by having the Medicaid provider subcontract with one or more providers to provide supports to people who are homeless or at risk of homelessness. The Medicaid provider could reimburse a supportive housing provider for services and supports provided by the supportive housing provider. The Medicaid provider will either pass through the reimbursement to the supportive housing provider or charge a small administrative fee.

Supportive housing providers should identify their local Employment Networks for individuals with SSI and SSDI who would like to use their ticket for the ticket to work program. Supported housing agencies can be a great source of referral to the Employment Network who often have a difficult time locating individuals with tickets.

- ***Recommendation #13: Enhance Knowledge Regarding Employment Supports.***

The Department of Children and Families and the Department of Education should develop and deliver training, information materials, etc., on employment resources for use by homeless and supportive housing service providers, case managers, community support workers, and other direct service staff working to assist people with disabilities succeed in permanent supportive housing. Such training and information could parallel the statewide training on tenancy supports recommended in this report. State MHBG or PATH funds could be used to develop the necessary training materials and deliver training throughout the state. Training content would include information on Workforce Investment Act, TANF and TWWIA services and access criteria; information on successful models for increasing employment for homeless individuals and people living in permanent supportive housing; and information on successful approaches to working with

employment specialists in local One-Stop Career Centers and other employment service providers. With regard to TWWIA, the training content should include information on when Tickets to Work will be issued; which providers are designated as Employment Network service providers by MAXIMUS; and how people's SSI and Medicaid benefits can be protected while earned income from employment increases.

- ***Recommendation #14: Create Greater Opportunities for Interorganizational Planning.***

DCF should require regular interorganizational activities such as mutual planning sessions, service development activities, and conferencing on individual service access where appropriate. The purpose of these activities is for the local homeless and supportive housing providers and the local employment providers to get to know each other and develop personal and professional working relationships designed to facilitate access to mainstream employment resources. From the perspective of the One-Stop Centers and other employment service providers, such relationships could facilitate access on the part of unemployed people to affordable housing, other public benefits, and follow-along supports necessary to increase the success rate of employment placement activities. The outcomes of these meetings should include quicker and easier access to employment resources; improved employment service delivery methods tailored to the needs and choices of adults with disabilities who are homeless or living in supportive housing; and improved delivery of community services and supports tailored to the employment and vocational rehabilitation service plan for each individual.

Conclusions

The preceding recommendations present several options that the Florida Supportive Housing Coalition could pursue to obtain additional services and supports for individuals in supportive housing. These recommendations must be evaluated and prioritized over the next few months to ensure that the FSHC targets its resources strategically. For instance, pursuing new state general revenue funds may not produce immediate results and generate significant frustration. However, supporting the Department of Children and Families in their efforts to implement the new home and community-based waivers would provide ample opportunities for supportive housing providers and developmental disability providers to enhance funding opportunities for housing and supports.

Employment for individuals in supportive housing is also an area that should be considered a priority. Individuals with disabilities explicitly state their need for opportunities for meaningful activities, most often work. The Ticket to Work program presents great prospects for individuals to receive the necessary training and supports needed to return to the workforce. In addition, the promise of a real Medicaid “buy-in”

program would increase incentives for individuals to pursue employment opportunities without the fear of losing their health benefits.

Finally, the FSHC must continue to develop and enhance its relationship with agencies that provide supports and services. New leadership at the Florida Council of Community Mental Health allows an opportunity for FSHC to discuss issues and solutions to accessing these needed services and supports.