Medicaid & Permanent Supportive Housing: A Quick Guide for Health Centers

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To promote the state-level opportunities to further develop permanent supportive housing (PSH) models, the U.S. Department of Health and Human Services, through the Assistant Secretary for Planning and Evaluation, recently published two documents that provide an in-depth analysis of the strategies for using Medicaid to provide the services needed for a vulnerable population: *A Primer on Using Medicaid for People Experiencing Chronic Homelessness and Tenants in Permanent Supportive Housing;*[1] and *Medicaid and Permanent Supportive Housing for Chronically Homeless Individuals: Emerging Practices from the Field.*[2] Together, this pair of reports covers a wide range of information related to chronic homelessness, the services needed to support this population in PSH, the Medicaid authorities and options available to states to support these services, and payment mechanisms and delivery structures that further enhance PSH for providers and patients alike. This fact sheet is intended to briefly outline the elements contained in the primer so that health centers serving individuals experiencing homelessness may better understand the current opportunities for promoting this model of care.

Health Centers, Medicaid, and Permanent Supportive Housing

Health centers authorized under Section 330 of the Public Health Services Act provide comprehensive primary health care and preventive services (including behavioral health services) to people who are uninsured and underinsured. Recognizing that people experiencing homelessness have unique and complex needs, Congress authorized Section 330(h) Health Care for the Homeless (HCH) grants to develop programming and services tailored to meet these needs. In 2012, the Health Resources and Services Administration (HRSA) released a change in how people experiencing homelessness are defined with respect to 330(h) funding to include residents of PSH programs or other housing programs that are targeted to homeless populations in an effort to promote continuity in care with patients who have established relationships with their HCH providers.[3] Numerous HCH grantees now provide primary care, behavioral health, and/or other services in supportive housing in order to ensure that previously homeless patients remain stable in housing.

The successes of PSH are well-documented, but due to a lack of consistent financing there are noticeable challenges to bringing these models to scale. There are few funding streams that are specifically designed to cover services in supportive housing; moreover, grant funding tends to be time-limited, undermining the permanence of these programs. To overcome this challenge, states are beginning to look at Medicaid as a sustainable funding source for the services needed by people living in PSH. As the HHS documents make clear, there are many ways that states can cover supportive services in PSH under Medicaid. States have flexibility to adopt one or more options, each having their own requirements for participation, set of services that can be covered, and possible eligibility restrictions. In order for health centers to take advantage of Medicaid financing for services in PSH, it is important to understand which options certain patients will qualify to receive and whether or not the health center is able to provide these services. Based on their patient needs, health centers could consider which Medicaid option to look into with the State Medicaid agency weighing the administrative and operational responsibilities that come with delivering services under each option.

The *Primer* discusses Medicaid authorities and options, providers and settings separately from Medicaid benefits and services. It then explores medical necessity of services (e.g., who can receive specific services) before discussing Medicaid payment mechanism. To simplify the information, the tables at the end of this brief provide an overview of each option and authority before detailing the services that each option covers.

Furthering Health Center Involvement: Actions to Consider

Health centers serving homeless populations are at the forefront of PSH service structures, but each health center is in a unique position to further develop its involvement in PSH and obtain Medicaid reimbursement for the range of services provided. Below are steps to consider for those beginning new programs or services in this area, while also providing some suggestions for grantees looking to strengthen existing activities. Ultimately, health centers are key community partners to help grow PSH capacity to better meet the needs of individual clients as well as the larger community.

Developing New Programs or Services:

1. **Needs assessment and strategic plan:** Health centers are already required to periodically conduct needs assessments to determine the needs of their target populations and to update their service areas when appropriate.[4] Consider using or expanding upon existing assessment practices to identify supportive housing service needs in the community.
2. **Weigh statewide Medicaid options v. local implementation:** Consult with the State Medicaid agency regarding whether a statewide strategy—such as adopting Medicaid options—is feasible, or whether a more localized approach using grants is more likely to be implemented or manageable as a starting point.
3. **Health centers and services**: Assess the breadth and depth of services needed and how health center staff are best positioned to provide them. In some venues, the health center will be the sole provider of services and in others, there will be multiple providers.
4. **Identify a PSH provider and contract for needed services:** A successful program might start out by offering case management services offsite to a specified number of PSH residents.
5. **Define practice culture and priorities:** Work with the PSH provider to identify differences in practice style and develop a list of common priorities. Discuss any areas where cultures vary and collaboratively decide how to overcome these challenges to ensure a consistent approach to client care plan development and service provision.
6. **Establish how health center staff and PSH providers will communicate:** Discuss what information providers should be sharing, how it is to be shared, and who has access to this information. Often simply identifying an individual as a health center patient or a PSH consumer is sufficient. Note PSH providers do not normally need detailed health information such as diagnosis or specific services received, or full access to medical records (particularly for behavioral health conditions or sensitive information like HIV status). Put in place a clearly defined protocol to prevent inappropriate information sharing that might violate the Health Insurance and Portability and Accountability Act of 1996 (HIPAA) or the Alcohol and Drug Abuse Patient Records Privacy Law.[5]
7. **Review outreach and engagement activities:** Review current outreach strategies used by health center staff to determine how they can include individuals in PSH and incorporate these activities into the service agreement with PSH providers.
8. **Develop relationships between landlords and case management staff:** Open an ongoing dialogue between landlords (especially for scattered site PSH) and case managers since these staff can help proactively address a landlord's concerns with consumers to ensure they remain stably housed.
9. **Partner with the local Continuum of Care (if applicable):** Discuss how the HUD-funded services coordinated through the Continuum of Care could complement those provided by the health center to better serve those in PSH.
10. **Meet with State Medicaid staff:** Talk with Medicaid leadership about the need for PSH models to serve a high-need population and share local data (as well as data from other states) to further demonstrate the advantages to pursuing Medicaid coverage for services. Ask which Medicaid options might be most feasible to implement these models, realize improved health outcomes, and generate cost savings.

Strengthening Existing Programs or Services:

1. **Identify frequent user population:** Partner with PSH and local hospitals to identify individuals with frequent emergency department and hospital admissions and develop a plan to coordinate services (refer from hospital to health center, then connect to housing) and prioritize high risk individuals for housing.
2. **Document homeless status in medical records.** Ask hospital administrators to promote the use of ICD codes to identify homeless patients. Codes for homelessness are v60 for ICD-9 and z59 for ICD-10. *Since many health care providers are currently transitioning from ICD-9 to ICD-10, this is an ideal time to request these codes be used to document homeless status.*
3. **Consider opportunities to finance needed services such as intensive case management, care coordination and case conferencing**: Such services, using funding mechanisms described in the table, will improve cross-sector health care delivery, promote stronger partnerships, and reduce fragmentation in care.
4. **Assess health center scope:** If there are gaps in the Scope of Project (e.g., if the health center wishes to provide services at a new location or add additional services), health centers may submit a Change in Scope to HRSA. This must be submitted 60 days prior to any intended change.[6]
5. **Allow clinical providers to access electronic health records offsite:** Having remote access to medical records during a home visit in PSH will ensure that providers have full information related to a patient's care, are aware of any alerts that might be present in a patient's record, and ensure more timely and comprehensive documentation.
6. **Assess electronic health record (EHR) capacity:** Health centers should review their current EHR capacity and determine costs for upgrading systems or adding new features for collecting and reporting needed data. Consider how upgrades might increase provider efficiency, as well as assist the health center capture, extract and analyze meaningful data elements for quality improvement.
7. **Identify external assessment providers:** Some Medicaid options require independent assessments for eligibility and for care plans. Learn which entities your State Medicaid agency works with to conduct assessments and consider how your health center can help inform these assessments (particularly when patients may be reluctant or unable to provide all the needed information).
8. **Develop a care transition protocol:** As patients become more independent and stable, they may wish to seek care at another health center. Your care transition protocol should ensure that important health information is delivered to the new health care provider, time is allocated to familiarize the client with the new provider team, and the patient experiences a smooth transition.
9. **Use medical respite programs to help patients transition into housing:** Medical respite programs are ideal venues for stabilizing patients while they transition from the street/shelter into housing. With an average length of stay of 40 days in medical respite programs, patients can recuperate from acute conditions, apply for housing opportunities, and further develop skills to promote housing stability.
10. **Share outcomes data widely.** To make a stronger case for continued Medicaid investments in PSH services, health centers should regularly analyze client outcomes data and share the results with a wide range of stakeholders.

Conclusion

Health centers are ideal service providers for those living in PSH, and there are numerous opportunities within Medicaid to help finance additional benefits needed to ensure better health and stable housing. Administrators and clinicians at health centers serving homeless individuals can use this fact sheet as a guide for developing new programs that link patients to PSH, or to further grow existing programs.

Services in Permanent Supportive Housing

The following table summarizes the services described in *A Primer on Using Medicaid for People Experiencing Chronic Homelessness and Tenants in Permanent Supportive Housing*[1] and some of the approaches to covering these services, including various Medicaid options. These services reflect the broad range of care that many people experiencing homelessness need to stabilize/improve their health and attain/retain housing stability, hence tend to be part of supportive housing models of care. It is important to consider patient needs when determining the most appropriate services to provide. As needed, these services may be combined to address many issues, and some are covered under multiple Medicaid options.

Benefit/Service Type	**Description**	**Modes for Covering Service** (Note: 1115 Waivers may support any of the services described in this table)
Primary Care	Health centers have the ability to receive Medicaid reimbursement for providing primary care services and integrated care services in permanent supportive housing. To do so, they must include these services and locations in their HRSA-approved Scope of Project.	Federal Health Center Program grants; Medicaid Federally Qualified Health Center (FQHC) Services; 1915(b) Waiver - Medicaid Managed Care(if covered in state plan); Health Homes; Medicaid 1905(a)
Mental/Behavioral Health Care	Medicaid can reimburse health centers for mental health services and/or substance use services provided to individuals in permanent supportive housing, including psychotherapy and individual and group counseling. These must be outlined in the Scope of Project and the provider must meet state licensing standards.	Federal Health Center Program grants; Medicaid FQHC Services; Rehabilitative Services; 1915(b) Waiver - Medicaid Managed Care;
Integrated Care	Integrated primary health care services that include behavioral health services is essential when providing services to individuals in PSH, as many individuals who have experienced chronic homelessness have both physical health and behavioral health conditions. Medicaid most frequently finances integrated primary care and behavioral health services which are provided through partnerships between separate organizations, rather than a single entity.	Federal Health Center Program grants; Medicaid FQHC Services; Health Homes; 1915(b) Waiver - Medicaid Managed Care (if covered in state plan)
Case Management including Referral and Linkages	Case management services seek to link individuals to appropriate services. "Targeted case management" is billable as a separate Medicaid benefit for targeted populations as determined by the State and includes specific requirements related to comprehensive assessment, development of a specific care plan, referral and linkage, and follow-up activities.	Federal Health Center Program grants; Medicaid FQHC services (if provided as part of a billable primary or behavioral health care encounter)(Targeted Case Management; Health Homes; 1915(b) Waiver - Medicaid Managed Care (if covered in state plan); Home and Community-Based Services
Substance Use Disorder Services	Substance use services and recovery supports for individuals with serious mental illness (SMI) and co-occurring substance use disorders can be included within the scope of rehabilitative services covered by Medicaid and may be provided by community support or Assertive Community Treatment (ACT) teams.	Federal Health Center Program grant; Medicaid FQHC Services; Targeted Case Management; Rehabilitative Services; 1915(b) Waiver – Medicaid Managed Care (if covered in state plan); Health Homes; Home and Community-Based Services
Care Coordination	Care coordination services not only help an individual achieve housing stability, they also assist the individual in accessing all needed services and bridging different care entities, such as primary care, behavioral health care, and housing.	Health Homes; 1915(b) Waiver - Medicaid Managed Care (if covered in state plan)
Home Health Services	For individuals with difficulty accessing health care, home health services break down barriers (e.g., transportation, mobility limitations, etc.) by bringing service providers to the individual's home.	Medicaid 1905(a); Medicaid managed care; Home and Community-Based Services
Case Consultation/Team Conferences	Team conferences provide a care team the opportunity to share information about client needs and functioning, in addition to collaborating on how to support the client in achieving goals. This style of collaboration, involving meetings of the entire multidisciplinary care team, is an efficient means of communication and making care decisions.	Rehabilitative Services; Targeted Case Management; Health Homes; 1915(b) Waiver - Medicaid Managed Care (if covered in state plan)

Benefit/Service Type	Description	**Modes for Covering Service** (Note: 1115 Waivers may support any of the services described in this table)
Diversionary Services	Diversionary services promote the use of more cost-effective outpatient resources and other service supports to individuals who would otherwise receive care in an inpatient or institutional setting. Diversionary behavioral health services may include community crisis stabilization; community-based acute treatment services for substance use disorders; community support services; partial hospitalization; structured outpatient addition programs; Programs of Assertive Community Treatment (PACT) for community-based psychiatric treatment; and intensive outpatient programs.	Primarily 1115 Waiver
Assertive Community Treatment (ACT)	ACT teams provide comprehensive community-based treatments, rehabilitation and support services for individuals with severe mental illness (SMI). The multi-disciplinary ACT team tailors services to meet the individual's specific needs and delivers integrated services to help the individual meet their goals. Services are changed over time in response to changing needs. Teams may be comprised of providers working in primary care, mental health, substance use treatment, and other social services.	Rehabilitative Services
Medication Management	Individuals who have been unstably housed may have difficulty obtaining medication. These individuals may benefit from assistance obtaining appropriate medication and education on medication management.	Rehabilitative Services, 1915(c), 1915(i)
Peer Support	Peer support can be covered by Medicaid if peers are providing counseling and support services to eligible adults with mental illness and/or substance use disorders.	Rehabilitative Service
Mobile Crisis Services	Medicaid will reimburse for mobile crisis services provided to individuals in PSH. This improves access to services for individuals with SMI and substance use disorders.	Rehabilitative Services
Medication-Assisted Treatment	Medication-assisted treatment is pharmacological treatment combined with behavioral therapies for the treatment of individuals with substance use disorders. This intervention can be covered by optional Medicaid benefits.	Federal Health Center Program grant; Rehabilitative Services
Care Plan	Developing an individualized care plan is essential when working to address a person's unique needs. Care plans can be developed under some Medicaid covered services to connect the individual to available services.	Targeted Case Management; Home and Community-Based Services; Health Homes; 1915(b) Waiver - Medicaid Managed Care (if covered in state plan)
Follow-up	Following-up with the individual and service providers can help to ensure that the care plan is being implemented and effectively addressing the individual's needs.	Targeted Case Management
Daily Living Skills	Services can be offered through Medicaid options to enhance an individual's life skills, such as education on financial and medication management and using community resources.	Home and Community-Based Services; Rehabilitative Services (those skills related to social behavior, emotional well-being, and self-care); Targeted Case Management; 1915(b) Waiver - Medicaid Managed Care (if covered in state plan)
Caregiver Respite	Respite care, in the case of HCBS, means temporary support services for the caregiver of a person with a disability. This is not the same as medical respite care.	Home and Community-Based Services

Modes of Service Coverage

The following table summarizes some of the available approaches, including various Medicaid Options, through which the specific services can be covered, and discusses eligibility and points of consideration for each method. The State must determine which approach would be the most effective and efficient use of resources for providing the desired mix of services. They must consider the financial cost/benefit balance, the methods of providing services, and the potential administrative and operational burden.

Modes to Deliver &/or Pay for Care	Description	Services Covered	Eligibility	Consideration
Federally Qualified Health Center (FQHC) Services	The term FQHC is defined in the Medicare and Medicaid statutes (Titles XVIII and XIX of the Social Security Act, respectively). It is used by CMS to indicate that an organization/entity is approved to be reimbursed under Medicare and Medicaid using specific methodologies (laid out in statute) for FQHCs. FQHC services are provided in PSH. For HRSA supported Health Center program grantees, services can be funded through their federal grants (HRSA) or Medicaid reimbursement at their PPS rate if services and the service area are within the health center's approved scope. Health centers can only be reimbursed for services that are covered in the State Medicaid plan. Covered services may differ from state to state. Health centers can also provide services through other state Medicaid options.	Primary Care; Mental/Behavioral Health Care; PPS rates can bundle other services that may not be independently reimbursable such as Integrated Care, Outreach, and Case Management	Health centers provide services to everyone, regardless of insurance status or ability to pay.	Health centers must meet criteria set forth by HRSA, such as demonstrating need, and be located in a medically underserved area. Health centers have the ability to provide services outside of the health center facility if they explicitly include additional locations in their Scope of Project. For Medicaid reimbursement purposes, the PSH services must also be covered under the State Medicaid plan, which may differs from state to state.
Rehabilitative Services	Rehabilitative services are intended to reduce an individual's disability and restore the individual's functioning. States can define which services are covered and locations in which services can be provided (e.g. home visits). Services should be individualized based on consumer needs. It does not cover educational and job training services, habilitation services, recreational and social activities.	Examples of services that may be covered: Assessments; Assertive Community Treatment (ACT); Psychotherapy; Counseling; Medication Management; Peer Support; Mobile Crisis Services; Medication Assisted Treatment	Medicaid beneficiaries must meet state criteria for services. Some states have expanded eligibility to individuals who have a diagnosis of schizophrenia, other psychotic diagnosis, bipolar disorder, and major depressive disorder	The Rehabilitative Services option offers flexibility to cover services delivered in a range of settings. Reimbursement is available for services recommended by a physician or other licensed practitioner. States may have additional qualifications for providers, including licensing or team composition requirements (i.e., requiring teams to have a primary care provider). The rehabilitative service benefit allows for services to be provided face-to-face, and at state option, by telephone, or by telemedicine and may be provided anywhere in the community. Services must be documented in a way that shows that the intervention addresses identified needs.

Modes to Deliver &/or Pay for Care	Description	Services Covered	Eligibility	Consideration
Targeted Case Management	States can seek Medicaid funding for targeted case management (TCM) services, which are intended help individuals access medical, social, educational, and any additional services.	Comprehensive Assessment and reassessment; Care Plan Development; Referral and Linkage; Monitoring and Follow-up	Medicaid beneficiary; Meet state criteria for services	States have the ability to target this option to specific subpopulations, which may be defined by geographic region or medical condition. Health centers will need to determine patient eligibility for coverage under this option. States use varied reimbursement methodologies for targeted case management services, dependent in part on the provider rendering the service. These have been generalized for purposes of this table as follows: fee for service, cost based payment, prospective payment, or capitated payment for the population to be served. Some states negotiate payment rates.
Health Homes	Health homes provide a comprehensive system of care coordination for individuals with chronic conditions who are enrolled in Medicaid. Health Homes must offer comprehensive care management, care coordination and health promotion, comprehensive transitional care, and individual and family support, and must use health information technology to link services. States have flexibility in who is eligible to be a health home provider. Health home providers can be individual providers, a team of health care professionals, or a health team that provides the health home services and meets established standards and system infrastructure requirements.	Primary Care; Mental/Behavioral Health Care; Integrated Care; Care Management; Care Coordination; Referral/Linkage; Team Conferences; Case Consultation; Patient & Family Support	Medicaid beneficiary With two or more chronic conditions, with one chronic condition and at risk for a second, or with a serious and persistent mental health condition	The Health Home option allows flexibility in designing payment methodologies: permits tiered-payment and allows alternative payment models. Providers must submit quality measures to state and states must take part in an impact assessment. This option provides a 90% Federal Medicaid Assistance Percentage for the first eight fiscal quarters.[7]
Home and Community-Based Services (HCBS)	HCBS provide opportunities for Medicaid beneficiaries to receive services in their own home or community. These programs serve a variety of targeted population groups, such as people with mental illnesses, intellectual or developmental disabilities, and/or physical disabilities. 1915(c) waivers authorize the use of HCBS services for individuals with an institutional level of care. States have the ability to cover multiple target groups under one waiver and may have an unlimited number of active 1915(c) waivers. States may also determine criteria under a 1915(i) state plan option to provide HCBS services to individuals with less-intensive care needs. A state can elect to expand services to an individual who is not otherwise eligible for Medicaid if the individual meets need-based and income-based criteria and will receive 1915(i) services.	Case management; Homemaker services; Home health aide; Adult day health services; Habilitation services; Respite care For people with chronic mental illness: Day treatment or other partial hospitalization services; Clinic services; Other services as approved	Medicaid beneficiary; Requires an institutional level of care for §1915(c) waiver (defined by state); needs-based criteria defined by state for §1915(i) state plan option.	If a state is considering the HCBS option, they need to weigh the cost and benefits of 1915(c) versus the 1915(i) state plan option. The 1915(c) waiver requires demonstration of cost neutrality, while the 1915(i) waiver does not. The 1915(c) can be geographically limited while 1915(i) must be statewide.[7] Under a 1915(c) waiver the state must specify a maximum number of participants per year.

Modes to Deliver &/or Pay for Care	Description	Services Covered	Eligibility	Consideration
1115 Research and Demonstration Waiver	1115 waivers can be used to support innovative health care initiatives that include services that are typically not reimbursable as long as States maintain budget neutrality. States have used 1115 waivers to expand Medicaid coverage to those who do not meet current categorical or income-based eligibility criteria. States have also used 1115 waivers to support diversionary services (described above). Programs under an 1115 waiver may be geographically focused and can be exempt from the statewide Medicaid requirement.	Highly flexible – may include: Enhancing daily living skills; Service coordination and linkage; Assisting with obtaining benefits, housing, and health care; Developing a crisis plan; Prevention and intervention; Linkages to peer support/self-help	Must meet criteria defined in CMS approved state 1115 waiver	1115 research and demonstration waivers offer the most flexibility and do not require comparability of services, freedom of choice, or statewide implementation. This waiver type requires budget neutrality and rigorous evaluation of the demonstration project,[7] which may lead to more administrative burden than other waiver types.
1915(b) Waiver	States are allowed to implement managed care plans that restrict the types of providers people may use to get Medicaid benefits. 1915(b)(3) allows states to use savings from a managed care delivery system to provide additional services, if approved. This waiver type does not require comparability of services, freedom of choice, or statewide implementation.	Primary Care; Behavioral Health; Care Plan; Respite Care; Case Consultation/Team Conferences; Integrated Care; Case Management; Substance Use Disorder Services; Care Coordination; Daily Life Skills	Medicaid beneficiary; Meet state criteria for services (e.g., geographic area if applicable, part of targeted population)	A 1915(b) waiver requires states to demonstrate cost-effectiveness. There may be greater administrative burden associated with 1915(b) than other waiver types (i.e. 1915(a)). A 1915(b) waiver allows states to identify excluded populations and waives the requirements for statewide implementation.[7] The 1915(b) waiver approval is limited to two years, where managed care plans under the Medicaid state plan authority do not expire.[8]

Further Resources:

- (ASPE) *Medicaid and Permanent Supportive Housing for Chronically Homeless Individuals: Emerging Practices From the Field* (August 2014): http://aspe.hhs.gov/daltcp/reports/2014/EmergPrac.cfm
- (ASPE) *A Primer on Using Medicaid for People Experiencing Chronic Homelessness and Tenants in Permanent Supportive Housing* (July 2014): http://aspe.hhs.gov/daltcp/reports/2014/PSHPrimer.cfm
- (CSH) *The Quick Guide to Improving Medicaid Reimbursement for Supportive Housing Services* (April 2015)

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[1] Burt, M., Wilkins, C., and Locke, G. (July 2014). *A Primer on Using Medicaid for People Experiencing Chronic Homelessness and Tenants in Permanent Supportive Housing.* Available at: http://aspe.hhs.gov/daltcp/reports/2014/PSHPrimer.cfm;

[2] Burt, M., Wilkins, C., and Locke, G. (August 2014). *Medicaid and Permanent Supportive Housing for Chronically Homeless Individuals: Emerging Practices from the Field*. Available at: http://aspe.hhs.gov/daltcp/reports/2014/EmergPrac.cfm.

[3] Macrae, James. (April 2012.) Memorandum to John Lozier, Executive Director, National Health Care for the Homeless Council. (This memo indicates that HRSA will issue official guidance on this matter.) Available at: http://www.nhchc.org/wp-content/uploads/2011/10/macrae-memo-12-mo-rule.pdf. A subsequent policy advisory from Mr. Lozier to HCH grantees further clarifies the 25%/12-month rule change and is available at: http://www.nhchc.org/wp-content/uploads/2011/10/12-month-rule-Policy-Advisory-Sept-20122.pdf.

[4] Public Health Services Act, Section 330(k)(2) and Section 330(k)(3)(J).

[5] More information on both these provisions is available at http://www.samhsa.gov/laws-regulations-guidelines/medical-records-privacy-confidentiality.

[6] Bureau of Primary Care (Retrieved March 2015). *Scope of Project.* Available at: http://www.bphc.hrsa.gov/about/requirements/scope/index.html

[7] Center for Health Care Strategies and Mathematica Policy Research (April 2012). *"At a Glance" Guide to Federal Medicaid Authorities Useful in Restructuring Medicaid Health Care Delivery or Payment.* Available at: http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/At-a-glance-medicaid-Authorities.pdf

[8] Center for Medicaid and CHIP Services (Retrieved March 2015). *Managed Care.* Available at: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html