

July 2000

HOMELESSNESS

Barriers to Using Mainstream Programs



GAO

Accountability * Integrity * Reliability

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Abbreviations

DDS	Disability Determination Service
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HRSA	Health Resources and Services Administration
HUD	Department of Housing and Urban Development
GAO	General Accounting Office
SAMHSA	Substance Abuse and Mental Health Services Administration
SSA	Social Security Administration
SSI	Supplemental Security Income
TANF	Temporary Assistance for Needy Families
USDA	U.S. Department of Agriculture
VA	Department of Veterans Affairs
WIA	Workforce Investment Act



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July 6, 2000

Congressional Requesters

Low-income people, including those who are homeless, can receive a wide range of assistance—such as housing, food, health care, transportation, and job training—through an array of federal programs, such as the Food Stamp Program and Medicaid. These programs, often referred to as mainstream programs, are generally designed to help low-income individuals either achieve or retain their economic independence and self-sufficiency. However, in the late 1980s, the Congress recognized that existing programs were not effectively meeting the needs of homeless people. Consequently, to develop a comprehensive federal response to homelessness, the Congress passed the Stewart B. McKinney Homeless Assistance Act in 1987. The act established programs providing emergency food and shelter, those offering longer-term housing and supportive services, and those designed to demonstrate effective approaches for providing homeless people with other services, such as physical and mental health care, education, and job training. Originally, many of the programs authorized under this act were intended to provide targeted, emergency relief to the homeless population and were appropriated at about \$350 million in 1987. A decade later, this amount had increased to about \$1.2 billion annually, and much of the assistance these programs now provide often mirrors the assistance available through the mainstream programs. Even with this expansion, however, experts generally agree that the McKinney Act programs, by themselves, cannot adequately meet the needs of homeless people and that mainstream programs must be made more accessible to this population.

Concerned about the ability of homeless people to obtain assistance through federal mainstream programs, you asked us to determine (1) why homeless people cannot always access or effectively use federal mainstream programs and (2) how the federal government can improve homeless people's access to, and use of, these programs. To address the first objective, we interviewed, and reviewed documents obtained from, federal officials, representatives of national advocacy and policy organizations, providers of services to homeless people, and individuals who were currently or formerly homeless. We focused in depth on barriers to seven key mainstream programs. Information on these programs can be found in appendixes I through VII. To address the second objective, we

convened a panel of eight nationally recognized experts on homelessness; the views of panel members are included in appendix VIII.

Results in Brief

Homeless people are often unable to access and use federal mainstream programs because of the inherent conditions of homelessness as well as the structure and operations of the programs themselves. While all low-income populations face barriers to applying for, retaining, and using the services provided by mainstream programs, these barriers are compounded by the inherent conditions of homelessness, such as transience, instability, and a lack of basic resources. For example, complying with mainstream programs' paperwork requirements and regularly communicating with agencies and service providers can be more difficult for a person who does not have a permanent address or a phone number. Furthermore, the underlying structure and operations of federal mainstream programs are often not conducive to ensuring that the special needs of homeless people are met. For example, federal programs do not always include service providers with expertise and experience in addressing the needs of homeless people. These providers may not be organized or equipped to serve homeless people, may not be knowledgeable about their special needs, or may not have the sensitivity or experience to treat homeless clients with respect. In addition, the federal government's system for providing assistance to low-income people is highly fragmented, which, among other things, can make it difficult to develop an integrated approach to helping homeless people, who often have multiple needs.

Alleviating these barriers would require the federal government to address a number of long-standing and complex issues. The expert panel we convened discussed a variety of strategies the federal government could pursue to improve homeless people's access to, and use of, mainstream federal programs. These included (1) improving the integration and coordination of federal programs, (2) making the process of applying for federal assistance easier, (3) improving outreach to homeless people, (4) ensuring an appropriate system of incentives for serving homeless people, and (5) holding mainstream programs more accountable for serving homeless people. Most of these issues are not new, and federal agencies have tried to address them for years with varied degrees of success. At the same time, however, panel members noted that federal agencies could do more to incorporate into mainstream programs the various lessons learned from McKinney Act programs and demonstration projects targeted to homeless people. These demonstration projects have developed effective

approaches to serving homeless people in such areas as mental health, substance abuse treatment, primary health care, housing, and job training.

Background

Homelessness in America is a significant and complex problem. The exact number of homeless people is unknown, but research by the Urban Institute, conducted in 1987 and still widely cited today, estimated that over a 1-week period, approximately 500,000 to 600,000 people lived on the streets or in emergency shelters.¹ According to a survey conducted for the federal Interagency Council on the Homeless in 1996, in the year prior to the survey, 60 percent of homeless people (excluding children in homeless families) who used homeless assistance programs had an alcohol and/or drug problem, and 45 percent had a mental health problem.² While nearly all homeless people are extremely poor, it is generally the combination of this poverty with other vulnerabilities—such as lack of education or job skills, severe mental illness, substance abuse, or lack of family and social supports—that results in homelessness. The homeless population is far from homogenous. For many homeless people, particularly those in homeless families, homelessness is a short-term or episodic event; these individuals may require little more than emergency shelter to get them through a difficult situation. For other homeless people, particularly those with severe substance abuse or mental health disorders, homelessness is a chronic condition; these individuals may require intensive and ongoing supportive services in addition to housing. As a result, the types of mainstream assistance that different homeless people and families require vary greatly.

¹Martha R. Burt and Barbara E. Cohen, *America's Homeless: Numbers, Characteristics, and Programs that Serve Them* (Washington, D.C.: The Urban Institute Press, July 1989).

²The "1996 National Survey of Homeless Assistance Providers and Clients" was designed and funded by 12 federal agencies under the auspices of the Interagency Council on the Homeless, a working group of the White House Domestic Policy Council. The U.S. Bureau of the Census collected the data, which the Urban Institute analyzed.

Homeless people can be served by two types of federal programs: (1) those targeted to the homeless population, such as the programs authorized under the McKinney Act, and (2) those designed to assist all eligible low-income people. As we reported in 1999, 50 key federal programs administered by eight federal agencies provided services to homeless people.³ Of these 50 programs, 16 were specifically targeted to homeless people and 34 were mainstream programs designed for low-income people in general. In fiscal year 1997, the federal government obligated about \$1.2 billion for targeted programs and about \$215 billion for mainstream programs.

Services available through federal mainstream programs are delivered to eligible individuals in a variety of ways. Some federal programs, such as Supplemental Security Income (SSI), are largely administered by the federal government, while others, such as the Food Stamp Program, are administered by the states under broad federal guidelines. Still other programs, such as the Substance Abuse Prevention and Treatment Block Grant, are administered by the federal government as grants to states and communities and provide considerable discretion to grantees in using these funds. In addition, many of the services, such as health care and job training, that are funded by federal mainstream programs are ultimately provided to eligible individuals by “service providers,” who are typically local, nonprofit organizations. As a result, the extent to which the federal government can influence program implementation and service to the homeless population varies significantly according to the structure of the mainstream program.

Characteristics of Homelessness and Federal Programs Can Impede the Ability of Homeless People to Use Mainstream Programs

The characteristics of homelessness—transience, instability, and a lack of basic resources—mean that homeless people often find it more difficult than other low-income people to apply for, retain, and use the services provided by federal mainstream programs. At the same time, the underlying structure and operations of federal mainstream programs are often not conducive to ensuring that homeless people are well served. This is because federal programs may not always include service providers with expertise and experience in addressing the needs of homeless people and because these programs may lack incentives that encourage mainstream service providers to serve this population. Also, the fragmented nature of

³*Homelessness: Coordination and Evaluation of Programs Are Essential* (GAO/RCED-99-49, Feb. 26, 1999).

federal mainstream programs can create barriers to providing a coordinated set of services that addresses the multiple needs of homeless people.

Homelessness Itself Creates Obstacles in Accessing and Using Federal Mainstream Programs

While all low-income people face various obstacles in accessing and using federal mainstream programs, the special circumstances of homeless people greatly compound these obstacles, as well as create unique obstacles. Homelessness is characterized by a lack of resources and stable housing, and homeless people suffer disproportionately from a variety of personal problems, such as poor health, mental illness, and substance abuse disorders. The combination of these conditions can exacerbate obstacles to (1) getting information about mainstream programs and fulfilling their administrative and documentation requirements, (2) communicating and meeting with mainstream service providers, and (3) effectively using the services provided by mainstream programs.

Information, Administrative, and Documentation Obstacles

Homeless people may lack information about federal programs and services that can assist them. While a lack of information about services can be an obstacle to all low-income people, homeless people are less likely to have access to as many sources of information as people who are housed, in part because they are less likely to be connected with a community. As a result, homeless people may be unaware of their eligibility for a program or how to apply for it. In addition, mental illness, substance abuse, and other personal problems common among the homeless population can interfere with obtaining information about mainstream programs.

The application process for mainstream programs presents additional obstacles. The process can be lengthy and complicated and can involve considerable paperwork. For example, to receive SSI, which provides cash benefits to eligible blind, disabled, and aged individuals, an applicant must complete a 19-page application form, be interviewed by a claims representative at a Social Security Administration district office, provide the names and addresses of doctors and hospitals that have their medical records, and document income and resources. It takes an average of nearly 3 months between the time an individual applies for assistance and receives an initial decision. However, if the application is denied and the applicant files an appeal, a final decision may take over a year. This complex process and long wait can be difficult for all applicants but present special problems for homeless people, whose personal conditions and lack of stable housing can make it particularly difficult to negotiate a

complicated process. Moreover, many homeless people have literacy or language problems or developmental disabilities, which can inhibit their ability to read and fill out application forms.

Providing the required documentation is essential to obtaining federal assistance but can be particularly problematic for homeless applicants. Many mainstream programs require applicants to provide documents proving their identity, citizenship, income, and financial resources, among other things. However, homeless people often do not have these documents because they do not have a safe and secure place to store important papers. For example, in 1998, the National Law Center on Homelessness and Poverty found that working homeless people are not always able to receive the Earned Income Tax Credit because they are unable to obtain and keep the tax forms needed to document their earned income. Similarly, because homeless people often receive medical care at various locations, including emergency rooms and clinics at scattered sites, they may have difficulty providing the location of their complete medical records to document their disability, as required for SSI and other programs.

Communication and Transportation Obstacles

Communication difficulties can hinder homeless people in applying for assistance from mainstream programs. The application process for many programs can involve multiple contacts—in person, on the telephone, or by mail—between the applicant and one or more program offices. Failure to respond to a request for information from a program or to meet certain deadlines can delay an applicant's receipt of benefits. Like many other low-income people, homeless people may lack a telephone, but they are also more likely to lack a reliable mailing address. As a result, communicating with program offices can be difficult. For example, applicants for public housing are typically put on a waiting list until housing becomes available, which can be several months or years. When a homeless applicant reaches the top of the list, the housing authority maintaining the list may be unable to contact the applicant to offer housing. As a result, the homeless applicant may either be deleted from the list or moved to the bottom of it.

Communication problems can continue once a homeless person enrolls in a federal program. For example, without a dependable mailing address, a homeless family may have difficulty receiving, on a reliable and consistent basis, the cash benefits available through the Temporary Assistance for Needy Families program. Communication difficulties can also create obstacles to receiving consistent medical care, including care provided through federally supported programs such as Medicare, Medicaid, and the Community Health Center program.⁴ A homeless person without a telephone or mailing address may have difficulty making and keeping scheduled appointments and arranging for appropriate follow-up care.

For many low-income people, the contacts necessary with program offices and service providers are also made difficult by a lack of transportation. This problem is common among homeless people, who are less likely to own a car and whose minimal resources may make public transportation unaffordable. Without adequate transportation, it is more difficult to apply for benefits or attend the interviews required as part of the application processes. Transportation difficulties can also hinder the ability of homeless people to use the services they need, such as medical care, job training programs, and outpatient programs for substance abuse treatment.

Obstacles Posed by the Lack of Stable Housing

Without stable housing, homeless people face certain practical constraints on their ability to effectively use many federal mainstream programs. For example, homeless people generally have no place to store or refrigerate food purchased with food stamps, and the program does not allow them to use food stamps to purchase hot prepared foods from grocery stores. As a result, they may be less able to maintain a nutritious, healthy diet. Recognizing this problem, the Congress amended the Food Stamp Act in 1990 to allow homeless people to redeem their food stamps at certain authorized restaurants for hot meals; however, few restaurants are enrolled in this program.

In addition, the use of managed care by state Medicaid programs may increase barriers to health care for Medicaid beneficiaries who lack stable housing. Managed care can have the advantage of giving homeless people a single and consistent “medical home” where they can receive services. At the same time, managed care organizations often operate under a tightly controlled set of rules that may not always be compatible with the

⁴The Community Health Center program is a federal grant program that helps fund health centers serving medically underserved populations.

circumstances of someone without a fixed place to live. For example, managed care organizations usually require that care be provided at specific locations, which may not be feasible for someone who is homeless and transient.

The lack of stable housing can also create obstacles to receiving effective substance abuse treatment, which may be funded in part through the federal Substance Abuse Prevention and Treatment Block Grant program. Substance abuse treatment programs often provide outpatient rather than residential treatment. However, many experts on homelessness and substance abuse treatment believe that outpatient treatment is unlikely to be effective for many homeless people because they do not have the stable and substance-free living environment needed for successful recovery. Moreover, many outpatient mainstream treatment programs have requirements that may not always be feasible or realistic for someone who is homeless, such as requiring daily contact with a case manager or requiring the individual to be sober upon admittance to the program.

Underlying Structure and Operations of Federal Programs Can Result in Barriers for Homeless People

The underlying structure and operations of federal mainstream programs are often not conducive to ensuring that the special needs of homeless people are met. Specifically, these programs (1) may not include service providers with experience and expertise in serving homeless people; (2) may inadvertently create disincentives for serving homeless people; and (3) are highly fragmented, which, among other things, can make it difficult to provide homeless people with coordinated care.

Mainstream Service Providers May Not Have Experience and Expertise in Serving Homeless People

According to many service providers, advocates,⁵ and homeless people we spoke with, mainstream programs often do not include service providers with experience and expertise in serving homeless people. These providers may not be organized or equipped to serve homeless people, may not be knowledgeable about their special needs, and may not have the sensitivity or experience to treat homeless clients with respect. For example, many providers delivering Medicaid services for states are not adept at dealing with homeless patients' special needs and characteristics, such as their inability to store medicines or their lack of adequate shelter, nutrition, and

⁵The advocacy organizations we contacted for this report included both those that focus on issues of homelessness, such as the National Coalition for the Homeless and the National Alliance to End Homelessness, and those that advocate for broader populations, such as the National Low Income Housing Coalition and the Food Research and Action Center.

hygiene. Many Medicaid providers are also generally not organized to integrate medical care with other needs, such as substance abuse treatment, nutrition, and housing, which is often required to effectively treat homeless patients.

Similarly, recent changes to the federal government's system for providing job training may affect the supply of job training providers with expertise serving homeless people. The Workforce Investment Act of 1998 allows communities to use contracts to fund specific providers but directs the majority of resources toward job training "vouchers," which are provided to individuals needing assistance. Some advocates and service providers have expressed concerns that the emphasis on individual vouchers could result in less funding for providers that specialize in training hard-to-serve individuals, such as homeless people.

Mainstream Programs May Not Provide Adequate Incentives for Serving Homeless People

Federal mainstream programs may not provide adequate incentives for service providers to serve the homeless population. Homeless people often have multiple needs, more severe problems, and fewer resources than other segments of the low-income population. Therefore, they can be a comparatively more expensive and difficult population to serve. States, localities, and service providers who receive federal funds but face resource constraints may therefore be deterred from making the special efforts that are needed to reach out to and serve the homeless population. For example, although overall federal grant funding to community health centers has not decreased, the proportion of health center revenues that these grants represent has declined steadily over the past several years, and the advent of Medicaid managed care has reduced some centers' Medicaid revenues. As a result, according to health center representatives and other providers we spoke with, community health centers are constrained in their ability to allocate resources toward outreach and services for homeless people.

In addition, the federal government's performance-based approach to measuring program outcomes, while beneficial in many respects, can inadvertently create disincentives to states, local areas, or individual providers to serve the most challenging populations, such as homeless people. This is because programs that focus on hard-to-serve populations, such as homeless people, may not have outcomes that are as successful as programs that focus on more mainstream and easier-to-serve populations. For example, the Workforce Investment Act holds states, communities, and service providers accountable for performance measures, such as success rates in placing people in jobs and improving earnings. However, to be

effective, states and communities will need to adjust performance standards on the basis of the characteristics of different populations. According to some advocates and service providers for homeless people, across-the-board performance standards may act as a disincentive for job training programs to serve homeless people. Such standards, they say, may serve to penalize programs serving populations with multiple barriers to success, such as homeless people. A Department of Labor official told us that although the act does not require that performance measures be adjusted to reflect the characteristics of different populations, it does allow the states and local areas, if they choose, to do so.

Fragmentation of Federal Programs Can Cause Barriers

As we and others have reported in the past, the federal government's system for providing services and benefits to low-income people is highly fragmented. In part, this is because these programs have developed incrementally as the Congress created programs over a period of time to address the specific needs of low-income individuals and families. Some fragmentation of these programs may be inevitable because many serve different missions, or fragmentation may be constructive because it allows the states and localities to design their own programs in response to local needs and preferences. At the same time, the fragmentation of federal assistance programs can create difficulties for low-income people in accessing services, and it particularly affects the homeless population in several ways. For example:

- Each federal assistance program usually has its own eligibility criteria, application, documentation requirements, and time frames; moreover, applicants may need to travel to many locations and interact with many caseworkers to receive assistance. While all people needing assistance may find it confusing and time-consuming to navigate this complex system of programs, the obstacles inherent in homelessness only compound these difficulties.
- The fragmentation of federal programs can make it difficult for homeless people to receive an integrated system of care. Numerous studies have demonstrated that the multiple and complex needs of homeless people—which may include medical care, mental health care, substance abuse treatment, housing, income support, and employment services—should not be addressed in isolation but rather through programs that are integrated and coordinated.
- Fragmentation at the federal level also creates fragmentation at the local and provider levels, according to service providers, advocates, and government officials we spoke with. States, localities, and service providers administering multiple federal programs have to contend with

different program regulations, operating cycles, and limits on the use of funds for the various programs. This hinders their efforts to effectively coordinate mainstream programs at the state and local levels. Often, to overcome the problems caused by fragmentation in the mainstream programs and to develop services that meet the multiple needs of homeless people, program administrators must cobble together funding from a variety of different federal sources.

Alleviating Barriers to Mainstream Programs Requires Addressing Complex Underlying Issues

Many experts on homelessness believe that the federal government will have to address a number of long-standing and complex issues in order to reduce the barriers that homeless people face in accessing and using mainstream programs. To help us identify the actions and strategies that federal agencies could implement to alleviate these barriers, we convened a panel of nationally recognized experts on homelessness. These panelists identified a number of changes or strategies that would help mainstream programs better serve the homeless population:

- The federal government needs to better integrate and coordinate federal programs, both to facilitate integration and coordination at the community level and to improve the care that is provided to homeless people with multiple needs.
- The process of applying for federal assistance should be made easier through, for example, efforts that allow people who need assistance, including homeless people, to apply for several programs simultaneously.
- Mainstream programs need to conduct greater outreach to homeless people, such as sending program staff to shelters, soup kitchens, and other locations where homeless people congregate.
- A better system of incentives is needed to help ensure that mainstream programs adequately serve homeless people by, for example, making certain that the high cost of serving this population does not become a disincentive for providing them with adequate services.
- Mainstream programs need to be more accountable for adequately serving homeless people by, for example, encouraging programs to track the numbers and outcomes of the homeless people they serve. (See app. VIII for more detailed information on the panelists' views.)

The issues the panel members identified are not new to the federal agencies responsible for administering mainstream programs. These agencies have been trying to address some of these challenges for many years, with varying degrees of success. For example, with regard to improving coordination and simplifying the application processes, the Department of Health and Human Services (HHS) developed an information system design in the 1980s that facilitated state efforts to combine the eligibility determination process for Medicaid, the Food Stamp Program, and Aid to Families With Dependent Children.⁶ In addition, several states are planning or implementing their own automated systems to coordinate the delivery of services provided by multiple federal programs. However, these projects have faced several serious challenges, owing, in part, to the complexity of the system of aid for low-income people and the difficulties inherent in managing any large information technology project. Similarly, in terms of increasing accountability, the Government Performance and Results Act of 1993 requires federal agencies to collect performance data and use these data to hold programs accountable for their performance. However, as we reported in 1999, the extent to which federal agencies are using this process to hold mainstream service providers more accountable for serving homeless people is not yet clear. This issue of program accountability is further complicated by the fact that many federally funded services are now provided through block grants, which give the states and localities wide discretion in administering programs. A purpose of the Federal Financial Assistance Management Improvement Act of 1999 is to improve the effectiveness and performance of federal grant programs. Federal agencies are working with the Office of Management and Budget to develop uniform administrative rules and common application and reporting systems, replace paper with electronic processing in the administration of grant programs, and identify ways to streamline and simplify grant programs.

Federal agencies have developed a large body of knowledge about serving homeless people effectively through the McKinney Act programs and various demonstration and research projects targeted to homeless people. These programs and demonstration projects clearly show there are strategies mainstream programs can adopt to better serve the homeless population in such areas as mental health, substance abuse treatment,

⁶Aid to Families With Dependent Children, which provided eligible families with monthly cash assistance, was replaced by the Temporary Assistance for Needy Families block grant for the states.

primary health care, housing, and job training. In 1994, we recommended that the Secretaries of Housing and Urban Development (HUD), HHS, Veterans Affairs, Labor, and Education incorporate the successful strategies for working with homeless people from the McKinney Act demonstration and research projects into their mainstream programs. While the federal agencies have taken some steps to implement our recommendation, members of our expert panel emphasized that these efforts have not been adequate. They said that federal agencies need to do more to incorporate the “best practices” for serving the homeless population that have been learned from past demonstration and research projects into mainstream programs.

Agency Comments

We provided a draft of this report to the departments of Agriculture, HHS, HUD, and Labor, as well as the Social Security Administration, for review and comment. These agencies advised us that they agreed with the information presented in the report, and USDA, HHS, and the Social Security Administration provided us with some technical comments that we have incorporated, as appropriate.

In addition, HHS provided us with general comments that stated that the report’s categorization of the problems and barriers experienced by homeless people in accessing mainstream programs is useful. HHS also stated that it appreciated the report’s observations regarding the heterogeneity of the homeless population and the implication that a complex variety of mainstream programs must be considered. However, HHS disagreed with the report’s implication that outcomes for programs serving homeless people may not be as successful as outcomes for programs that serve other special populations, such as the gravely disabled or chronically ill. We agree with HHS that outcomes for programs serving homeless people can be as successful as programs serving other special populations. However, our report simply highlights that homeless people, like any population that faces special challenges, may be more difficult to serve than mainstream populations that do not face special challenges. As a result, performance measurement systems that compare the outcomes of hard-to-serve populations with those of other populations may put programs that focus on hard-to-serve populations at a relative disadvantage. (See app. IX for the complete text of HHS’ comments.)

Scope and Methodology

To determine why homeless people cannot always access or effectively use federal mainstream programs, we interviewed, and reviewed documents obtained from, officials at the departments of Agriculture, Health and Human Services, Housing and Urban Development, and Labor, as well as the Social Security Administration. In addition, we obtained information from representatives of national advocacy and policy organizations, including those that deal with issues of homelessness, housing, primary health care, mental health, substance abuse, nutrition, access to legal services, veterans' affairs, and youth welfare. We also met with representatives of organizations that provide services to homeless people, such as homeless shelters and transitional housing programs. In addition, we conducted four group interviews of 30 people who were either currently homeless or formerly homeless. While we sought to identify the barriers faced by homeless people across all federal mainstream programs, we focused in depth on seven key mainstream programs—the Community Health Center program, the Food Stamp Program, Medicaid, public and assisted housing, the Substance Abuse Prevention and Treatment Block Grant, Supplemental Security Income, and the job training activities provided under the Workforce Investment Act.

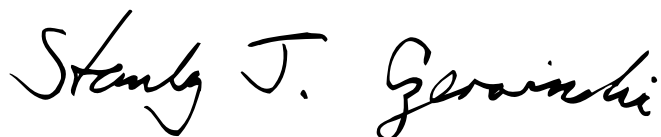
To determine how the federal government can improve homeless people's access to and use of federal mainstream programs, we convened a panel consisting of eight nationally recognized experts on homelessness. These individuals included officials from federal agencies and directors of advocacy and policy organizations concerned with the issue of homelessness. (The names and organizational affiliations of the panel members are listed in app. VIII.) We selected the panelists on the basis of recommendations we received during our audit work. At a day-long meeting at our offices in Washington, D.C., panel members developed recommendations for actions and strategies that the federal government could take to alleviate the barriers homeless people face in accessing and using federal mainstream programs. The meeting was recorded and transcribed to ensure that we had accurately captured the panel members' statements.

We performed our work between July 1999 and July 2000 in accordance with generally accepted government auditing standards.

This is the fourth and final report on issues concerning homelessness that we have prepared at your request. (See Related GAO Products.) We are

sending copies of this report to the appropriate congressional committees; the Honorable Dan Glickman, Secretary of Agriculture; the Honorable Donna E. Shalala, Secretary of Health and Human Services; the Honorable Andrew M. Cuomo, Secretary of Housing and Urban Development; the Honorable Alexis M. Herman, Secretary of Labor; the Honorable Kenneth S. Apfel, Commissioner of Social Security; and other interested parties. Copies will also be made available to others on request.

If you have any questions about this report, please call me or Anu Mittal at (202) 512-7631. Other key contributors to this report were Jason Bromberg, Lynn Musser, and John Shumann.

A handwritten signature in black ink that reads "Stanley J. Czerwinski". The signature is written in a cursive, flowing style.

Stanley J. Czerwinski
Associate Director, Housing
and Community Development Issues

List of Requesters

The Honorable Phil Gramm
Chairman, Committee on Banking, Housing and Urban Affairs
United States Senate

The Honorable Pete V. Domenici
Chairman, Committee on the Budget
United States Senate

The Honorable James M. Jeffords
Chairman, Committee Health, Education,
Labor and Pensions
United States Senate

The Honorable Arlen Specter
Chairman, Committee on Veterans' Affairs
United States Senate

The Honorable Christopher S. Bond
Chairman, Subcommittee on VA, HUD and
Independent Agencies
Committee on Appropriations
United States Senate

The Honorable Wayne Allard
Chairman, Subcommittee on Housing and Transportation
Committee on Banking, Housing and Urban Affairs
United States Senate

The Honorable Bill Frist
Chairman, Subcommittee on Public Health
Committee on Health, Education, Labor and Pensions
United States Senate

Food Stamp Program

This appendix provides information about the barriers that homeless people face in accessing and using the Food Stamp Program. This program, which is administered by the U.S. Department of Agriculture (USDA), provides low-income individuals with paper coupons or an electronic card that can be redeemed for food items at authorized food stores. Misinformation about the program, administrative difficulties, and a lack of outreach may create obstacles to homeless people in accessing food stamp benefits. In addition, because homeless people often lack facilities for refrigeration, storage, and food preparation, they may face obstacles in using the Food Stamp Program effectively.

Background

In fiscal year 1999, the Food Stamp Program provided 18.2 million people with an average of \$72 in food stamps each month. The Food Stamp Program is a federal-state partnership, with USDA's Food and Nutrition Service paying the full cost of food stamp benefits and approximately half the states' administrative expenses. States are responsible for administering the program, including determining applicants' eligibility and calculating and issuing benefits.

Homeless people, like all low-income individuals, may apply for the Food Stamp Program at state or county welfare offices. The application form varies from state to state and is between 7 and 20 pages long. Applicants who meet income and resource requirements receive food stamp benefits within 30 days of submitting their application. Most homeless people, because of their very limited resources and income, qualify for expedited service and can receive food stamps within 7 days of applying. As a result of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, able-bodied adults without dependents are required to meet certain work requirements in order to maintain their eligibility for food stamp benefits.

USDA does not collect data on the number of homeless people who are participating in the Food Stamp Program. Although the Food Stamp Program is an entitlement program that is available to nearly all low-income people, a 1996 survey conducted for the federal Interagency Council on the Homeless found that only 37 percent of the homeless people surveyed were receiving these benefits.

Homeless People May Face Barriers in Receiving and Applying for Food Stamps

While some service providers for homeless people told us that it is relatively easy to apply for the Food Stamp Program, others said that their homeless clients face numerous obstacles in accessing the program. One of the primary obstacles cited by the service providers and advocates we spoke with was misinformation about the program's eligibility requirements. For example, some homeless people incorrectly believe that they need a permanent address to receive food stamps. Moreover, the implementation of Temporary Assistance for Needy Families (TANF) has led to confusion among some food stamp applicants and eligibility workers about the eligibility requirements for the program. In 1999, we reported that some people were under the false impression that applicants must qualify for TANF in order to qualify for the Food Stamp Program.¹ According to some providers and homeless people we spoke with, this misinformation can deter homeless people from applying for benefits.

The process of applying for the Food Stamp Program can also create certain obstacles for homeless people. Transportation to the local welfare office, which can be difficult for all low-income people, can serve as a particular obstacle for homeless people, who often do not have private transportation, and who may find public transportation inaccessible or unaffordable. Furthermore, the application form can be difficult for some homeless people to complete, particularly those who suffer from a mental illness. Moreover, once they are receiving benefits, food stamp recipients who cannot reasonably predict their income from month to month—which is the case for many homeless people—are required to recertify their eligibility every 1 to 2 months. This recertification process is similar to the initial application process and can be particularly burdensome for someone with an unstable housing situation, who may not have access to a mailing address, phone, or reliable transportation. In addition, according to some service providers and homeless people, caseworkers at local welfare offices, who administer the Food Stamp Program, can be rude or disrespectful, and may not make the special efforts required to assist someone who is homeless.

Outreach efforts can help ensure that eligible homeless people are enrolled in the Food Stamp Program. These outreach efforts can include such things as sending caseworkers to local homeless shelters and helping individuals

¹*Food Stamp Program: Various Factors Have Led to Declining Participation* (GAO/RCED-99-185, Jul. 2, 1999).

complete their food stamp applications. In 1993 and 1994, USDA's Client Enrollment Assistance Demonstration Projects provided \$2.8 million to 26 local social service agencies to provide outreach for hard-to-serve populations, including homeless people. A final evaluation of these demonstration projects concluded that outreach can successfully increase the enrollment of hard-to-serve people in the Food Stamp Program if it is conducted by well-trained staff and tailored to match the characteristics of particular communities and populations.

However, according to a USDA official, because the Food Stamp Program is administered by the states, the decision to conduct outreach is left up to the states. USDA encourages the states to conduct outreach by offering technical assistance, distributing information about best practices for outreach, and providing informal encouragement. USDA also provides matching funds for states to conduct outreach to hard-to-serve populations, such as homeless people. However, in fiscal year 1999, only nine states took advantage of this funding.

Homeless People May Face Barriers in Using the Food Stamp Program Effectively

Homeless people may face certain obstacles in using the Food Stamp Program effectively because they lack facilities for refrigeration, storage, and food preparation. This can restrict the kinds and quantity of food they can purchase with their food stamps. For example, homeless people may need to purchase food items that are sold in single-serving containers and are nonperishable, which can restrict their choice of nutritious foods. Moreover, food stamps can be used to purchase cold single-serving foods (such as a sandwich or a quart of milk) but cannot be used to purchase hot foods prepared in a supermarket. Some service providers we spoke with suggested that USDA could expand its definition of "eligible foods" so homeless people could purchase hot foods prepared by the delicatessen departments of supermarkets and grocery stores. Recognizing the special circumstances of homeless people, the Congress amended the Food Stamp Act in 1990 to allow homeless people to redeem their food stamps at certain authorized restaurants for hot meals; however, few restaurants are enrolled in this program.

Public Housing and Section 8 Tenant-Based Assistance

This appendix provides information about the barriers that homeless people face in accessing public housing and Section 8 tenant-based assistance, which are overseen and funded by the Department of Housing and Urban Development (HUD). The repeal of federal preferences given to homeless people for public housing, changes in eligibility criteria, communication problems, and the difficulties homeless people may have finding a suitable unit using a Section 8 voucher can serve to impede homeless people's access to and use of public housing and Section 8 tenant-based assistance.

Background

HUD's two largest rental assistance housing programs—public housing and Section 8 tenant-based assistance—house more than 6 million people. Public housing is owned and operated by a local housing authority that provides housing units to low-income people. Section 8 assistance is privately owned housing that is federally subsidized. Section 8 assistance can be either project-based, which is linked to particular housing units, or tenant-based, which provides recipients with a voucher they can use at a housing unit of their choice.

All forms of assisted housing have certain eligibility criteria based on income status. In addition, federal housing assistance programs are generally available only to families with children, the elderly, and persons with qualifying mental or physical disabilities. As a result, single nonelderly adults without a qualifying disability—who constitute a significant proportion of the homeless population—occupy very few units of public housing and generally do not receive Section 8 assistance. In addition to its mainstream programs, HUD has housing programs specifically targeted to homeless people, such as the Supportive Housing Program and the Shelter Plus Care program.

Homeless People Face Numerous Barriers to Accessing Public Housing

The fundamental barrier that homeless people face in accessing public housing is its scarcity. The demand for public housing greatly exceeds the supply, and waiting lists for public housing (as well as other forms of assisted housing) are often very long. However, while the scarcity of public housing affects all low-income people needing housing assistance, recent changes in legislation have made it harder for homeless people, in particular, to access the limited available public housing, according to many advocates and service providers. Before 1996, the federal government required public housing authorities to give certain preferences

to households experiencing housing-related hardships, such as homelessness. In an effort to give public housing authorities more flexibility in their admissions and occupancy policies, the Congress suspended these federal preferences in 1996 and permanently repealed them through the Quality Housing and Work Responsibility Act of 1998. A HUD study issued in July 1999 found that, in response to this legislative change, nearly 60 percent of all public housing authorities had eliminated federal preferences, including the preference given to homeless people. The study did not gauge the effect these changes have had on the populations affected. However, according to housing and homelessness advocates and service providers, the loss of federal preferences for homeless people will almost certainly have a major effect on the ability of homeless people to access public housing. Homeless people will no longer automatically move up the waiting list in most areas, they say, resulting in fewer public housing units occupied by people who were formerly homeless.

Other changes made to the admissions and occupancy rules for public housing may also have reduced the ability of homeless people to secure units in public housing. The Quality Housing and Work Responsibility Act also allows public housing authorities to admit a greater proportion of relatively higher-income families into public housing. These provisions were designed to reduce the concentration of poverty in public housing. However, some advocates and service providers told us that this change will reduce the proportion of public housing units rented to people with very low income, including homeless people. In addition, other provisions of the law made it easier for housing authorities to exclude applicants with criminal convictions or a history of alcohol or drug abuse. While these provisions are aimed at making public housing safer, they may also further reduce access to public housing units for homeless people, many of whom have multiple personal problems.

Homeless people may face additional barriers to public housing because of communication difficulties. Although the initial process of applying for public housing is generally not difficult, communication problems between a housing authority and a homeless applicant can serve as a barrier once an initial application has been made. For example, applicants who have been deemed eligible for public housing are typically placed on a waiting list, which can be several years long in some locations. When a unit becomes available, an applicant is typically notified by telephone or mail and is required to respond within a certain period of time. Advocates and service providers told us that homeless people sometimes lose their spot in public

housing because they do not have a reliable mailing address or telephone number at which they can be contacted. In addition, when housing authorities update their waiting lists, they require applicants to respond in writing that they are still interested in a unit. Homeless people who lack a fixed address may get dropped from the waiting list because they did not receive the notice mailed to them. According to the housing and homelessness experts we spoke with, housing authorities vary greatly in the degree to which they make special accommodations to help applicants who are homeless overcome these obstacles.

Homeless People May Face Barriers to Using Section 8 Vouchers

Homeless people face many of the same eligibility and communication barriers to accessing Section 8 tenant-based assistance that they do to accessing public housing, since both programs are administered by public housing authorities and share the same basic application process. However, they may face additional challenges in using Section 8 vouchers once they receive them, because landlords are not required to accept a voucher and because the rent provided through the Section 8 program may not equal the rent a landlord can get on the private market. An October 1994 study prepared for HUD found that the rate of success in finding suitable rental units where the landlords would honor Section 8 vouchers was not significantly different for homeless and other participants. However, as rents rise and the supply of affordable housing drops in many parts of the country, there are concerns that homeless people will have an increasingly difficult time finding a suitable unit for the following reasons:

- Homeless people are more likely than other low-income people to lack a telephone, reliable transportation, and other means necessary to search for housing.
- The homeless population includes an especially large number of people with physical or mental health problems, which can interfere with the search for housing.
- Private landlords may not rent to homeless people who have Section 8 vouchers because they perceive homelessness to be an undesirable trait for potential tenants, according to advocates and service providers.

Employment and Training Services

This appendix provides information about the potential barriers homeless people face in accessing employment and training activities provided under the Workforce Investment Act of 1998 (WIA), which is to be fully implemented by July 1, 2000. Some advocates and service providers have raised concerns about the effects of WIA's use of job training vouchers and performance management on providing appropriate and effective employment and training services for homeless people.

Background

WIA is the legislation that provides the framework for the federal government's employment and training activities. It requires states and localities to establish workforce investment boards that develop employment and training systems and allocate the systems' resources within their community. Each local board develops a "one-stop" system that allows a job seeker or an employer to access an array of employment and training services in one place. The states are to fully implement WIA's job training provisions by July 1, 2000. The Congress appropriated about \$5.37 billion for fiscal year 2000 for activities authorized under title I of the act, which authorizes the new workforce investment system.

Employment services are essential for many homeless people to achieve economic self-sufficiency and move out of homelessness. According to a national survey conducted for the federal Interagency Council on the Homeless in 1996, 44 percent of homeless individuals surveyed were employed for pay in the 30 days prior to the survey, although only 13 percent had, at the time, a regular job that had lasted 3 months or more. While data are not yet available on the numbers of homeless people served by the activities funded under WIA, under its predecessor, the Job Training Partnership Act, about 2 percent of the 151,580 individuals served in program year 1998 by the act's adult programs were homeless.

Barriers to Accessing Job Training

Homeless people can be a particularly challenging population for providers of employment services. Homeless people often face serious personal barriers, such as alcoholism or a deficiency in basic skills, that need to be addressed before they are ready for employment or employment training. In addition, the transience, instability, and lack of basic resources characteristic of homelessness create certain practical obstacles to accessing job training programs. Not having a telephone or a reliable mailing address can impede access to these programs. Furthermore, homeless shelters may require that residents be in and out by certain times,

which may not coincide with the requirements of a training program. In addition, a lack of child care can be a major barrier to entering a job training program; homeless women, in particular, often do not have a place to leave their children during the day.

Recognizing the difficulty that homeless people may face in obtaining employment services, the Congress authorized the Job Training for the Homeless Demonstration Program as part of the Stewart B. McKinney Homeless Assistance Act. Conducted by the Department of Labor from 1988 to 1995, this program sought to develop effective ways of providing job training services for homeless people. The demonstration found that mainstream employment and training programs can be effective for homeless people if program providers adopt certain strategies. These strategies included such things as making special accommodations to help overcome obstacles related to the lack of a stable residence, providing special training to staff on the needs of homeless people, creating linkages with homeless service agencies, and providing homeless clients with access to a wide array of services beyond employment services.

Potential Concerns About Using WIA Job Training Vouchers

Because special strategies are needed to serve homeless people effectively, some advocates and service providers are concerned that certain provisions of WIA may hinder the ability of the homeless population to receive appropriate job training services. Under WIA's predecessor, the Job Training Partnership Act, most services were delivered through contracts with job training providers. Under WIA, however, most job training for adults is provided through Individual Training Accounts, also referred to as vouchers. Individuals who are unable to get or keep a job on their own may be referred to intensive case management services and undergo an assessment. If eligible, individuals may then be given a voucher that is used to "buy" training services from their choice of qualified providers. Some advocates and service providers for hard-to-serve populations have expressed concern that (1) the dollar value of the vouchers may not be sufficient to meet the training needs of homeless individuals who require more intensive services, (2) the network of "qualified providers" may not include enough providers with expertise in meeting the needs of hard-to-serve populations, and (3) homeless people may find the vouchers difficult to use and may not be in a position to choose the training programs most suitable for them.

A Department of Labor official responded to these concerns by noting that while WIA emphasizes the use of vouchers, it also allows the use of

contracts to serve special populations with multiple barriers to employment, including the homeless population. The official said that the degree to which these contracts are used to serve homeless people and other special populations will be largely determined by the decisions and efforts made by the state and local workforce investment boards.

Potential Concerns About WIA's Performance Accountability System

Some advocates and service providers are also concerned that WIA's performance accountability system may serve as a disincentive to states, local areas, or individual providers to serve homeless people. The act requires states and local areas to set performance goals and track the performance of job training programs by measuring job placement rates and the earnings of program participants, among other things. While this performance-based approach is beneficial in many respects, it can inadvertently discourage programs and service providers from serving the most challenging populations, such as homeless people, whose outcomes are not likely to be as successful as those of other program participants. According to some advocates and service providers for homeless people, across-the-board performance standards may serve as a disincentive for job training programs to serve homeless people. Such standards, they say, may serve to penalize community-based organizations and others who serve populations with multiple barriers to success, such as homeless people. A Department of Labor official told us that although the act does not require that performance measures be adjusted to reflect the characteristics of different populations, it does allow the states and local areas, if they choose, to do so.

Supplemental Security Income

This appendix provides information about the barriers that homeless people may face in accessing and using the Supplemental Security Income (SSI) program. SSI is administered by the Social Security Administration (SSA) and provides cash benefits to blind, disabled, and aged individuals whose income and resources are below certain specified levels. The complexity and duration of the SSI application process can create obstacles that are particularly difficult for people who are homeless.

Background

The SSI program is authorized under title XVI of the Social Security Act. In January 1999, 6.3 million people received a monthly average of \$341 in SSI benefits. To qualify for disability benefits, applicants must meet medical and functional disability criteria as well as financial eligibility requirements.

SSA does not collect data on the number of homeless people who receive SSI. However, a 1996 survey conducted for the federal Interagency Council on the Homeless found that 11 percent of homeless people were receiving SSI. The Congress changed the eligibility criteria for SSI so that starting in 1997 people who were previously eligible for SSI because of a diagnosis of alcohol and/or drug addiction were no longer eligible for benefits.

According to advocates and service providers for homeless people, this change may have reduced the number of homeless people who are eligible for SSI.

SSI Application Process Can Create Barriers for Homeless People

The SSI application process is complex and requires extensive documentation, which can create a number of barriers for homeless people. The SSI application form is about 19 pages long and includes detailed questions about living arrangements, resources, income, and medical history. Applicants must also provide a variety of documents to support the information on the application form. Completed applications are sent to the state's Disability Determination Service (DDS), which decides whether the applicant has an eligible disability as defined by SSA regulations. DDS officials may need to contact SSI applicants throughout the disability determination process to obtain additional information. DDS officials may also ask applicants to undergo a consultative medical examination paid for by SSA to help determine an applicant's disability status.

While all SSI applicants may find this application process challenging, service providers and advocates said it is particularly difficult for homeless people for the following reasons:

- Successfully completing the SSI application process may require multiple communications with the SSA office. However, homeless applicants are not always able to communicate regularly with employees at SSA because they may not have a permanent mailing address, a telephone, or transportation.
- Homeless people often seek medical care in emergency rooms and a variety of other facilities, so they often do not have a single medical provider who can provide their complete medical record. Homeless applicants are often unable to remember the names and addresses of physicians and hospitals that have provided care, which makes it more difficult for DDS to compile a medical record.
- Most homeless applicants apply for SSI on the basis of a mental disability, and a mental disability can be significantly harder to diagnose and document than a physical disability. In addition, many homeless people have a substance abuse disorder, further complicating the SSI process.

In addition, the documentation requirements for SSI can be particularly onerous for homeless people, who often do not have a place to store important papers or other possessions. All SSI applicants are required to provide a wide array of legal and financial documents. For example, an applicant must provide a Social Security card or record of a Social Security number, a birth certificate or other proof of age, payroll slips, bank records, insurance policies, car registration, and other information related to income and resources. Applicants applying on the basis of a disability must also provide documentation regarding their health status. According to service providers and advocates that we spoke with, homeless people often do not have these documents and information.

In addition to the complexity of the process, its length can create significant obstacles and hardships for people who are homeless, according to service providers and advocates for homeless people. SSI benefits may be the only income that some homeless people have, and the long wait for benefits makes it particularly difficult for them to afford basic necessities, such as housing, food, and clothing. According to SSA data, the average waiting time for an initial SSI disability decision in fiscal year 1997 was 80 days after the application was filed. However, 68 percent of the applications were initially denied. If an application is denied, applicants

can appeal the decision to DDS, then to an SSA administrative law judge, then to SSA's Appeals Council, and finally to the federal court system. Appeals are not uncommon for the SSI program; for example, in fiscal year 1997, more than one-quarter of the decisions to grant SSI were made by an administrative law judge. During that year, the process of appealing a denial through DDS and then to an administrative law judge took an average of 374 days from the time the appeal was filed. Under its fiscal year 2001 Performance Plan, SSA says it hopes to simplify SSI policies and issue disability decisions more quickly.

Because of the complexity and duration of the SSI application process, it is extremely difficult for most homeless people to successfully complete this process without assistance, according to service providers, advocates, and homeless people we spoke with. SSA does offer assistance to applicants who have difficulty producing information or records. However, homeless people who receive assistance in completing their SSI application typically receive such assistance through service providers or legal aid agencies, which help applicants fill out the required forms, maintain contact with SSA and DDS, and help obtain and provide medical documentation.

An SSA Outreach Demonstration Program in fiscal years 1990 through 1992 found that it can be difficult for homeless people to navigate the SSI application process by themselves; an advocate or caseworker is an essential part of the process for these applicants. Under this program, SSA awarded funds to 82 project sites to conduct outreach to special populations, including homeless people. Specifically, local nonprofit and human service agencies were given funds to educate individuals about the SSI program and assist them throughout the application process. This assistance included identifying eligible individuals who were not enrolled in SSI, providing application assistance, gathering medical evidence to support these individuals' applications, and tracking applicants for follow-up. SSI's evaluation report for the demonstration program found that these local service providers were able to effectively identify hard-to-serve eligible individuals, including homeless people, and help them complete the SSI application process. The evaluation recommended that SSA establish a strong organizational commitment to promote outreach. However, according to SSA, because of budget constraints, the agency does not currently have a national program to conduct outreach. SSA does direct its field offices to maintain contact with facilities such as homeless shelters but does not have any documentation of local outreach efforts.

Since 1991, SSA and the Department of Veterans Affairs (VA) have been conducting the SSA-VA Joint Outreach Initiative for Homeless Veterans.¹ Through this pilot project, SSA and VA staff work collaboratively at VA health care facilities to identify homeless veterans who are eligible for SSI and assist them in receiving their benefits as quickly as possible. A 1994 evaluation of the project found that it increased the rate of homeless veterans applying for and receiving SSI and decreased the duration of the application and decision process. However, this project serves only a limited number of homeless veterans; it is currently operating at four VA health care facilities nationwide and in fiscal year 1997 assisted 372 veterans with their applications, resulting in 56 awards of SSI benefits.

¹For more information on homeless veterans, see *Homeless Veterans: VA Expands Partnerships, but Homeless Program Effectiveness Is Unclear* (GAO/HEHS-99-53, Apr. 1, 1999).

Community Health Centers

This appendix provides information about the barriers homeless people may face in accessing and using health centers supported by the federal Community Health Center program. This program, which is administered by the Department of Health and Human Services' (HHS) Health Resources and Services Administration (HRSA), helps fund primary and preventive health care services in medically underserved areas. Homeless people face many of the same barriers to accessing services from community health centers that they face in accessing health services in general. In addition, financial constraints limit the amount of outreach to homeless people that community health centers undertake. Finally, these health centers do not always have the expertise or experience needed to adequately address all of the unique characteristics and needs of homeless people.

Background

The Community Health Center program provided approximately \$835 million in fiscal year 2000 to help fund approximately 650 community-based public and private nonprofit organizations that develop and operate community health centers nationwide.¹ In addition to providing medical services, community health centers provide other services that facilitate health care, such as health education, transportation, and linkages with other social services. According to a 1996 study by the HHS Office of Inspector General that surveyed 50 community health centers, about 2 percent of the centers' clients were homeless and about 3 percent of the centers' annual budgets went toward serving homeless people.

HHS also administers the Health Care for the Homeless program, which was created under the McKinney Act and awards grants to local public or private nonprofit organizations—including community health centers—to provide health care services that are targeted to the homeless population. About 10 percent of the approximately 650 federally-funded community health centers also receive an HHS grant to provide services under the Health Care for the Homeless program. This appendix focuses only on community health centers that do not have a Health Care for the Homeless component.

¹The Health Centers Consolidation Act of 1996 (P.L. 104-299, 110 Stat. 3626) combined programs for community health centers, migrant health centers, health care for the homeless, and primary care for residents of public housing into one. The consolidated appropriation for these programs was over \$1 billion in fiscal year 2000, of which funding for community health centers represented about 82 percent.

Conditions of Homelessness Can Cause Barriers in Accessing Community Health Centers

Although the mission of the Community Health Center program is to serve those populations that may lack adequate access to medical care, homeless people face many of the same barriers to accessing services from community health centers that they face in accessing health care services in general. Specifically, homeless people may

- be unaware of the health care services available to them through community health centers or where these centers are located;
- lack transportation to get to a community health center, particularly if it is not located in the central city;
- have difficulty making and keeping scheduled appointments because they have competing priorities for survival, such as finding food or shelter, or because they do not have easy access to a telephone; and
- not seek care because they fear or distrust large institutions, which is particularly the case for individuals who are mentally ill.

Because of these barriers, experts generally agree that special outreach efforts are required to ensure that homeless people receive access to adequate health care. These outreach activities can include disseminating health care information to homeless people and their service providers, providing direct services at homeless shelters or special clinics, and using mobile health units to serve homeless people living on the street. The Office of Inspector General study found that while 64 percent of the 50 community health centers surveyed provided outreach services for homeless people, the outreach did not always adequately ensure that homeless people had sufficient access to care.

Limitations in outreach efforts by mainstream community health centers do not generally stem from a lack of desire to serve the homeless population but rather from a lack of resources, according to service providers, advocates, and health center directors with whom we spoke. Community health centers face financial constraints that result, in part, from changes in their sources of revenue and in the overall health care environment. Although overall federal grant funding to health centers has not decreased, the proportion of health center revenues that these grants represent declined from more than 50 percent in 1980 to 23 percent by 1998. In addition, the growth of Medicaid managed care programs has reduced some centers' cost-based reimbursement from Medicaid, which is an important source of their revenues. Furthermore, community health centers are serving an increasing number of uninsured patients. As a result of these factors, many community health centers are unable to spend as

much as they would like on services such as outreach, transportation, and education, which help ensure access to health care for homeless people. The tight fiscal environment in which many community health centers operate also serves as a disincentive to making greater efforts to reach homeless people, who are a high-cost population to serve and are often uninsured.

Care Provided by Community Health Centers Does Not Always Meet the Needs of Homeless People

Community health centers typically have extensive experience in addressing the needs of underserved populations and providing culturally sensitive care to them. At the same time, according to some health care providers and advocates for homeless people, mainstream community health centers do not always have the expertise or experience needed to adequately address all of the unique characteristics and needs of homeless people. For example, because these centers serve relatively broad populations, they may not be organized to make some of the special accommodations homeless people may require. Community health centers typically work on a system of scheduled appointments, but homeless people may not be able to reliably make and keep such appointments. In addition, homeless people may have difficulty storing and refrigerating medications. Mainstream community health centers also do not usually have many of the special services that health clinics targeted to homeless people often have, such as a medical respite facility or laundry machines for patients' use.

Furthermore, while community health centers often link patients with welfare, substance abuse treatment, and other related services, their focus is largely on providing medical care. Since the health care needs of homeless people are often inextricably related to their need for other services—such as housing, food, clothing, and mental health and substance abuse treatment—a mainstream community health center, unlike a targeted program, may not have the capacity to address these various needs and services in an integrated fashion.

Because community health centers are largely autonomous, HRSA's efforts to improve homeless people's access to these health centers may be limited in their effectiveness. However, some providers and advocates we spoke with said they believe that HRSA could do more to encourage and facilitate health care for homeless people in mainstream community health centers. In addition, the 1996 Inspector General's report suggested several improvements HRSA could make, such as encouraging more collaboration and communication between the community health centers and nearby

homeless shelters. The Health Care for the Homeless program, which is also administered by HRSA, has taken several actions in the past few years to help ensure that homeless people are adequately served by those community health centers that do not have a Health Care for the Homeless component. These actions have included publishing and disseminating a book on organizing health services for homeless people; efforts to improve communications among community health centers, homeless shelters, and advocacy groups; and the development of “best practice” clinical guidelines for serving homeless people in mainstream health care programs.

Medicaid

This appendix provides information about the barriers that homeless people face in accessing and using health care services provided by Medicaid, a joint federal-state program that finances health care coverage for low-income individuals. Homeless people may have difficulty accessing Medicaid because problems with communication, documentation, and other factors associated with the inherent conditions of homelessness can impede the application process. In addition, there are some concerns about the use of Medicaid managed care and its effect on the care of homeless people enrolled in the program.

Background

In fiscal year 1998, the Medicaid program spent about \$177 billion to finance health coverage for over 40 million Americans. HHS' Health Care Financing Administration (HCFA) has oversight responsibility for Medicaid. Within broad federal guidelines, the states determine their specific eligibility criteria and the type of services they will provide. However, eligibility is mandatory for certain groups, including low-income families with children and most recipients of SSI. HCFA does not have comprehensive data on the number of homeless people enrolled in Medicaid. However, a 1996 survey of homeless people conducted for the federal Interagency Council on the Homeless reported that about 30 percent of homeless people surveyed were receiving Medicaid. Many homeless people are not eligible for Medicaid because they are childless adults who do not have a qualifying disability.

Conditions of Homelessness Can Create Barriers to Accessing Medicaid

Homeless people face a number of barriers accessing Medicaid because of the conditions associated with homelessness, according to service providers, advocates, federal officials, and homeless individuals who we spoke with. Among these barriers are the following:

- Some homeless people are unaware of the existence of the Medicaid program or do not know how to apply for it. Welfare reform may have exacerbated this problem because some homeless people incorrectly believe that they can qualify for Medicaid only if they qualify for TANF.
- The process of applying for Medicaid, which varies by state, can be complex and time-consuming, and can be particularly difficult for someone who is homeless. For example, a homeless person may not have a telephone or reliable mailing address, making it more difficult to schedule appointments and respond to follow-up inquiries with the local office that administers Medicaid. In addition, because homeless people

are often transient, it may be difficult to find them if follow-up information is needed to complete an application.

- Because homeless people often do not have a place to store papers, they may have difficulty providing the documentation that Medicaid may require to establish their eligibility based on income, resources, and medical history.
- States require individuals already on Medicaid to recertify their eligibility for the program every 6 to 12 months. A homeless person without a reliable mailing address is at greater risk of being inadvertently dropped from the program for not having responded to the mailed notice of recertification.

The barriers that we identified for Medicaid are consistent with the findings of a 1992 study conducted by the HHS Office of Inspector General. The study surveyed 298 directors of substance abuse or mental health treatment programs, state Medicaid staff, Social Security staff in district offices, and providers of services to homeless people. Many of the providers surveyed indicated that a significant number of the homeless people they served were not enrolled in Medicaid even though they were eligible for the program. These providers cited the complexity and length of the application process, the transience of the homeless population, and the difficulty of providing the necessary documentation as the major barriers that prevent homeless people from accessing Medicaid.

According to service providers and others we spoke with, outreach activities can be effective in reducing these barriers. These activities may include having agency staff visit homeless shelters to assist clients with the application and enrollment process, accompanying clients to appointments, helping them fill out forms correctly, and assisting them in gathering the necessary documentation. However, HCFA officials told us that because Medicaid is state-administered, the states vary considerably in the degree to which they conduct outreach to homeless people and accommodate their special needs. Although HCFA currently has various initiatives under way to improve Medicaid enrollment among certain populations, including some requirements for states to conduct outreach, these initiatives are not targeted specifically to homeless people.

Medicaid Managed Care May Create Additional Barriers for Homeless People

Increasingly, states are providing Medicaid coverage through managed care organizations. While managed care may have certain benefits for homeless people, it also raises concerns that it can create additional barriers to health care for this population.

Under a system of Medicaid managed care, states contract with managed care plans and pay them a fixed monthly, or capitated, fee per Medicaid enrollee to provide most medical services. In some states, Medicaid beneficiaries can choose whether to enroll in a managed care plan or a fee-for-service plan, while in other states enrollment in a managed care plan is mandatory. According to HCFA and other health care experts, enrollment in such a plan provides certain advantages for homeless people. For example, a managed care plan can provide homeless people with greater continuity of care by giving them a “medical home” where they can go to receive all of the services they need. In addition, unlike fee-for-service plans, managed care plans allow the state’s Medicaid agency to hold a single organization accountable for providing care.

However, homeless service providers, HCFA officials, and others also share concerns that the tightly controlled set of rules under which managed care operates may not be compatible with the circumstances of homeless people. For example, managed care organizations usually require that care be provided at specific locations that are either operated or affiliated with the managed care organization. This may not be feasible in the case of a homeless person, who may be transient and not easily able to go to a specific location for medical care. Furthermore, some health care providers told us that homeless people who are enrolled in Medicaid often are not even aware that they have been enrolled in a managed care plan and have little information about the plan and where they should go to obtain services.

Some service providers and advocates also have concerns that Medicaid payment policies may create disincentives for managed care organizations to provide homeless clients with the special services or adaptations they require. Because managed care organizations typically pay their providers a capitated rate based on the average cost per person of providing care, providers do not necessarily receive additional amounts for serving high-cost populations, such as the homeless. This can discourage mainstream providers from spending the additional money needed to effectively serve homeless people and conduct special outreach to this population. In addition, according to some service providers and advocates, a system of

fixed capitated payment rates may prevent the participation of providers who have more experience and expertise in treating homeless people, such as those involved in the Health Care for the Homeless program, since the capitation rate may not be sufficient to cover the increased costs these providers face in serving specialized populations.

HHS has been addressing the issue of homelessness and Medicaid managed care in several ways. HRSA funded two booklets to provide the states with guidance on developing and implementing Medicaid managed care programs that include homeless people. HRSA is also funding the development of model language that the states and others can use in their contracts with managed care organizations to help ensure that Medicaid managed care programs meet the needs of underserved populations, including homeless people. In addition, at the request of the Congress, HCFA began a study in 1997 to identify the safeguards needed to ensure that the health care needs of persons with special needs enrolled in Medicaid managed care are adequately met. Homeless people were one of six groups that the study focused on, and the draft report makes a number of recommendations to the states. According to HCFA officials and some advocates, because Medicaid is a state-administered program, the degree to which Medicaid managed care serves homeless people may depend in large part on whether and how states act on these proposed recommendations.

Substance Abuse Prevention and Treatment Block Grant Program

This appendix provides information about barriers that homeless people may face in accessing substance abuse treatment services funded through the federal Substance Abuse Prevention and Treatment Block Grant program. This program, which is administered by HHS' Substance Abuse and Mental Health Services Administration (SAMHSA), is the primary tool through which the federal government funds substance abuse treatment.¹ Homeless people may have limited access to effective substance abuse treatment programs because mainstream substance abuse treatment programs are not always appropriate or effective for homeless people and because states vary in the extent to which they devote their resources—including those received through the block grant—to serving the homeless population.

Background

The Substance Abuse Prevention and Treatment Block Grant program was appropriated \$1.6 billion in fiscal year 2000. These funds support the states and territories in planning, implementing, and evaluating activities to prevent and treat substance abuse. The states and territories receive grant awards according to a legislative formula, and the states have significant flexibility in how they allocate their block grant funds. Federal funding for public substance abuse treatment facilities, as a percentage of all funding used at the state level for substance abuse treatment, ranges from 11 percent to 84 percent, depending on the state.

While estimates vary on the prevalence of substance abuse in the homeless population, in a 1996 survey conducted for the federal Interagency Council on the Homeless, 60 percent of homeless individuals surveyed reported having had an alcohol and/or drug problem in the year prior to the survey. Fifty-two percent of those with a substance abuse problem during that time also had a co-occurring mental health problem. Substance abuse treatment experts generally agree that homeless people are among the most challenging populations to treat for substance abuse disorders—both because their addiction is often especially severe and because it is very difficult to effectively treat someone who lacks stable housing.

¹This appendix focuses on the treatment activities funded by the block grant and not on the prevention activities.

Mainstream Substance Abuse Programs Are Not Always Appropriate or Effective for Homeless People

Mainstream substance abuse treatment programs may not be appropriate or effective for many homeless people because the programs often do not take into account the unique needs and circumstances of homeless people, according to experts on homelessness and substance abuse. In particular, mainstream substance abuse treatment programs

- often have long waiting lists, which can cause hardships for homeless people because their situations are often especially dire and because they may be difficult to contact when a treatment slot becomes available;
- may have requirements that are not feasible or realistic for some homeless people, such as requirements for sobriety upon admission or daily telephone contact with a case manager;
- do not typically conduct the proactive street outreach that is needed to bring many homeless people into treatment;
- often rely on outpatient treatment rather than the residential treatment that experts say many homeless people need for effective recovery;
- tend to focus exclusively on an individual's addictive disorder, rather than addressing the multitude of needs, such as housing, health care, and income support, that also must be addressed for a homeless person to recover successfully; and
- are often ill-equipped or unwilling to integrate mental health treatment into the substance abuse treatment, which homeless people often require.

Extent to Which Block Grant Resources Serve Homeless People Is Unclear

Many advocates and service providers believe that the states often do not allocate enough resources towards substance abuse treatment options that are appropriate and effective for homeless people. While SAMHSA does not have definitive data on how federal block grant funds are used for homeless people, a SAMHSA official said the best information currently available is the Treatment Episode Data Set, which showed that in 1998 homeless people represented about 8 percent of all admissions into treatment programs receiving public funding (local, state, or federal). According to a 1998 National Coalition for the Homeless study of substance abuse services, the 13 states reviewed spent very little of their state and federal substance abuse treatment funds on services targeted to homeless people. A 1992 study by the HHS Office of Inspector General surveyed programs that received state funding through the federal Alcohol, Drug Abuse and Mental Health Services block grant.² Three-quarters of the 129 substance abuse treatment programs surveyed said they did not do outreach to, or make special services available to, the homeless population, even though most agreed that such special services were needed to serve homeless people effectively.

Unlike the Mental Health Performance Partnership Block Grant, which funds care for serious mental illness, the substance abuse block grant does not require the states to submit plans describing how they will provide outreach and services to homeless people. However, in its fiscal year 2001 block grant application, SAMHSA has requested that states provide data, on a voluntary basis, on the homelessness status of clients served through treatment programs. In addition, SAMHSA recently asked the National Association of State Alcohol and Drug Abuse Directors to collect data from the states to better understand how the states use block grant funds to serve the homeless population.

Some advocates and providers believe that more could be done to ensure that homeless people are served effectively by the resources of the substance abuse block grant. For example, they told us that states could be required to include plans for addressing the needs of homeless people in their block grant applications, and the states could be required to track the numbers and outcomes of homeless people enrolled in treatment programs. In addition, some advocates and service providers for the

²Federal funding to the states for mental health services and for substance abuse prevention and treatment services were combined in a single block grant until 1992.

homeless believe that the Congress should improve access to substance abuse treatment services for homeless people through either (1) an earmark within the existing block grant requiring that some portion of funding address the needs of homeless people or (2) the creation of a substance abuse treatment program targeted to homeless people. They noted that while there is a federal funding program targeted to homeless people with severe mental illness—the Projects for Assistance in Transition From Homelessness program—there is no similar funding program targeted specifically to the treatment of homeless people with substance abuse disorders.

As with any block grant, the Substance Abuse Prevention and Treatment Block Grant gives the states significant latitude in how they use this funding. In addition, the program does not require specific services for homeless people. Consequently, SAMHSA may have limited effectiveness in directing how block grant funds are used to meet the needs of homeless people. SAMHSA officials told us they work with state project officers to try to ensure that block grant funds and other resources are used to meet the needs of all populations, including homeless people. SAMHSA also recently started a strategic planning workgroup on homelessness issues to develop both short- and long-term strategies for better addressing the needs of homeless people. In particular, a SAMHSA official said the agency hopes to improve its dissemination of information to the states and communities on model treatment programs for homeless people, which could help encourage the states to use block grant dollars to serve homeless people more effectively.

Views of GAO's Expert Panel on Homelessness

This appendix provides the views of the expert panel that GAO convened on homelessness. The panel consisted of eight nationally recognized experts who, during a day-long meeting, discussed the issues the federal government should address in order to improve homeless people's access to and use of mainstream programs. All the ideas presented in this appendix may not represent the view of every member of the panel. Moreover, these ideas should not be considered to be the views of GAO.

Members of GAO's Expert Panel

The following individuals were members of GAO's expert panel on homelessness:

- Martha Fleetwood, Executive Director, HomeBase;
- Maria Foscarinis, Executive Director, National Law Center on Homelessness and Poverty;
- Mary Ann Gleason, Executive Director, National Coalition for the Homeless;
- Jean Hochron, Chief, Health Care for the Homeless Branch, Bureau of Primary Health Care, Health Resources and Services Administration, Department of Health and Human Services;
- Fred Karnas, Deputy Assistant Secretary for Special Needs Populations, Department of Housing and Urban Development;
- Walter Leginski, Senior Advisor on Homelessness, Department of Health and Human Services;
- Nan Roman, Executive Director, National Alliance to End Homelessness; and
- Carol Wilkins, Director, Health, Housing, and Integrated Services Network, Corporation for Supportive Housing.

Views of the Panelists

The panel members discussed a number of issues the federal government needs to address in order to improve homeless people's access to and use of mainstream programs. Specifically, panelists discussed actions and strategies the federal government could undertake related to (1) improving the integration and coordination of federal programs, (2) simplifying the process of applying for federal assistance, (3) improving outreach to homeless people, (4) ensuring an appropriate system of incentives for serving homeless people, and (5) holding mainstream programs more accountable for serving homeless people. Although the panel members were asked to limit their discussions to those ideas that would not require substantial increases in resources, many panelists emphasized that the lack

of resources is a fundamental barrier that prevents mainstream programs from better assisting homeless people.

Need for Better Integration and Coordination of Mainstream Programs

Panelists said that there is a need to reduce the fragmentation of programs at the federal level. This would not only improve access to mainstream programs for homeless people, they said, but would also facilitate the coordination of programs at the state and community levels and support the integration of care for homeless people who have multiple needs. More specifically, panel members discussed the following:

- Reducing federal funding restrictions in order to facilitate providing integrated care for people with multiple needs at the community level. For example, allowing communities to more easily combine mental health block grant funds with substance abuse block grant funds could make it easier for providers to serve individuals with co-occurring mental health and substance abuse problems. One panelist said that the states, localities, and service providers need clearer guidelines from the federal government on how to combine funds from different funding streams to serve individuals with multiple needs.
- Synchronizing federal funding cycles and consolidating funding of similar federal programs to make it easier for communities to coordinate their own programs and planning efforts.
- Incorporating the best practices on coordination and integration that have been developed from the McKinney Act's targeted programs for the homeless and from several federally funded demonstration projects. For example, federal agencies could benefit from adopting many of the strategies developed in the Access to Community Care and Effective Services and Supports demonstration project for integrating systems of care for homeless people.¹
- Revitalizing the Interagency Council on the Homeless with greater authority and resources.² Panelists said the Council needs to have the

¹Access to Community Care and Effective Services and Supports was a demonstration project that evaluated the effectiveness of integrated systems of care for homeless people with mental illness. It was sponsored by the Department of Health and Human Services and conducted from 1994 to 1999; the final results of the project are still being analyzed.

²The Interagency Council on the Homeless was established by the McKinney Act as an independent council, with its own funding and staff, to promote the coordination of homeless assistance programs across federal agencies. In 1994, the Congress stopped appropriating funds for the Council, and it became a voluntary working group under the President's Domestic Policy Council.

authority to effect changes at a policy level, not just at a program level, and the power to coordinate programs across agencies, rather than serve simply as a vehicle for discussion.

- Having the congressional committees and subcommittees with jurisdiction over the programs that affect homeless people take the lead on improving the coordination and integration of federal programs. The panelists urged congressional committees to consider the federal assistance system as a whole when drafting legislation, rather than creating individual programs that are not integrated with each other.

Need for Simpler and Unified Application Processes

Members of our expert panel said that simplifying the application processes for federal programs would facilitate homeless people's ability to access these programs. They said increased efforts could be made that would allow individuals seeking assistance to apply to several programs simultaneously. Panelists said that better use of technology could help achieve these goals. More specifically, panel members discussed the following:

- Using a core application form that gathers the basic information required for most federal programs, so as to reduce the need for applicants to provide the same information to multiple programs. Supplemental forms could gather the more detailed information required for certain programs. Improved linkages between the databases of different federal programs would be needed to make using a core application form feasible.
- Developing a database that would provide comprehensive information on all federal mainstream programs and benefits available to low-income people, including those who are homeless. This would help service providers give people needing assistance immediate and complete information on all of the different kinds of federal assistance for which they are eligible.
- Granting presumptive eligibility on the basis of homelessness for some federal programs, and granting provisional eligibility on the basis of homelessness while permanent eligibility is being established for other programs. In addition, one panelist noted that homeless people may need longer grace periods to comply with the requirements of the application processes.

Need to Provide Greater Outreach

Panel members said that greater outreach to homeless people is needed to ensure that they have access to federal programs. Panelists cited several activities that could be conducted to better reach homeless people. However, the panelists noted that outreach is more important for those programs that have the resource capacity to meet an increased demand, such as the entitlement programs, than it is for programs that have scarce resources to begin with. Panelists discussed outreach activities that included the following:

- Sending mainstream program staff to places where homeless people congregate, such as shelters and soup kitchens, so that they can encourage eligible individuals to apply for programs and assist them with the application process. Agencies could also make more use of satellite offices in areas where homeless people and other underserved populations live.
- More widely disseminating information about federal programs through more visual and creative methods. For example, videotapes produced by federal agencies could be used to train service providers about program rules and eligibility and to inform homeless people waiting in program offices about services available to them.
- Developing flexible pools of funds that providers of services to homeless people can use to engage homeless individuals, particularly those living on the street, and encourage them to reconnect with the community and take advantage of services available to them.

Need for an Appropriate System of Incentives

Our panelists stated that there is a need to create a system of incentives that encourage federal mainstream service providers to better serve homeless people. According to the panelists, federal programs must find ways of ensuring that the high cost of serving the homeless population does not serve as a disincentive to providers to serving this population. In addition, panelists said, performance-based incentives—which reward successful outcomes—need to be structured in a manner that does not penalize mainstream service providers who assist hard-to-serve populations, such as homeless people. Among the issues panel members discussed were the following:

- Ensuring that capitation rates for homeless people, under Medicaid managed care, reflect the true cost of providing medical care to this population.³ One panelist said that the federal government needs to conduct additional research on the health condition and medical costs of homeless people to help the states incorporate these costs into their capitation rates.
- Possibly providing higher reimbursement rates for tenants in public and assisted housing who have the fewest resources, such as homeless people.
- Setting aside earmarked (targeted) funds, or other kinds of financial incentives, to help ensure that the states and communities use block grant dollars to serve homeless people adequately.
- Encouraging localities to adjust performance measures for job training programs of the Workforce Investment Act so that they do not create disincentives for serving homeless people. Panelists said job training providers that serve homeless people should not be held accountable for achieving the same outcomes as those providers who serve less challenging mainstream populations.

Need for More Accountability for Serving Homeless People

The need for greater accountability was a recurring theme raised by panel members. They emphasized that the federal agencies, the states, communities, and service providers administering and operating federally funded mainstream programs need to be more accountable for adequately serving homeless people. Some of the ideas discussed by the panel members to achieve greater accountability included the following:

- Tracking the numbers and outcomes of homeless people served through federally funded programs is an essential first step toward developing a system of accountability.
- Developing a set of minimum standards for how block grant funds should address the needs of the homeless population that would help ensure that states and communities are held accountable for serving homeless people while still preserving the flexibility inherent in a block grant.
- Requiring recipients of some federal funds to address in their planning documents how they will serve the homeless population. For example, states could be required to develop plans for how the homeless

³A "capitation rate" is the fixed monthly amount given to a health plan for each enrollee under a system of managed care.

Appendix VIII
Views of GAO's Expert Panel on
Homelessness

population will be served with funds they receive from the Substance Abuse Prevention and Treatment Block Grant program.

- Creating a White House-level office on homelessness, analogous to the Office of National Drug Control Policy, to help focus responsibility and ensure accountability for the federal government's response to homelessness in one central and visible office.

Comments from the Department of Health and Human Services

Note: GAO comments supplementing those in the report text appear at the end of this appendix.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

JUN - 8 2000

Mr. Stanley J. Czerwinski
Associate Director, Housing and
Community Development Issues
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Czerwinski:

Enclosed are the Department's comments on your draft report, "Homelessness: Barriers to Using Mainstream Programs." The comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department also provided some technical comments directly to your staff.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely,

Michael Mangano
for June Gibbs Brown
Inspector General

Enclosure

The Office of Inspector General (OIG) is transmitting the Department's response to this draft report in our capacity as the Department's designated focal point and coordinator for General Accounting Office reports. The OIG has not conducted an independent assessment of these comments and therefore expresses no opinion on them.

COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES ON
THE U.S. GENERAL ACCOUNTING OFFICE'S DRAFT REPORT, "Homelessness:
Barriers to Using Mainstream Programs"

General Comments

The Department appreciates the observation of the General Accounting Office (GAO) regarding the heterogeneity of the homeless population and the implication that a complex variety of mainstream programs must be considered. Clearly, there is no one "program" or funding stream that offers a straightforward or immediate fix to the issue of mainstream access, either in the Department or among other Federal low-income assistance programs. The Department also found the taxonomy used by GAO to categorize problems and barriers experienced by homeless persons in accessing mainstream programs to be a useful one. It offered examples and reminders of inadvertent obstacles that restrict access or restrict compliance with a treatment regimen. The taxonomy was consistent with the recommendations of GAO's expert panel, particularly on issues of administrative obstacles, incentives, and system integration.

The Department does not agree with GAO's performance-measurement implication on pages 9 and 10 that programs that serve homeless persons may have outcomes that are "...may not be as successful..." as programs which do not include this group. There is no evidence that homeless persons are more exceptional than gravely disabled or chronically ill populations assisted by our resources. Health services supported by Department resources deal with serious, chronic conditions without concern that performance measurements must be tailored to the seriousness of health problems or excessively qualified by subpopulation differences. In addition, the Department has been the lead agency in demonstrating empirically that homeless persons can be engaged in treatment and effectively served.

In the absence of recommendations in the report, we cannot determine if GAO has assessed specific contributions the Department could make in the administration of its mainstream funding that would improve access for homeless persons. The GAO acknowledges that many mainstream programs are primarily Federal funding streams that allow States and localities to apply these resources to address self-determined needs (for example, pages 4 and 10). This certainly characterizes most of the Department's mainstream programs, where the authorizing legislation designates our responsibilities to provide oversight and monitoring, rather than to determine the nature of activities to be implemented. Neither GAO nor the expert panel recommendations identify a set of barrier-reduction strategies for a Federal agency that is administering a program that assists State and local entities to address their needs.

By implication, the presentation of recommendations from GAO's expert panel conveys one set of suggestions. The Department is pleased that we are responsive to several of these. On the issue of integration, we have implemented numerous activities within our operating divisions, within the Department, and with other Departments designed to reduce fragmentation. As an example of our most current effort, the Health Care Financing Administration (HCFA), the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Office of the Assistant Secretary for Planning and Evaluation are jointly funding a national conference in

See comment 1.

Appendix IX
Comments from the Department of Health
and Human Services

September 2000. The conference is intended to bring together a diverse group of policymakers, providers, consumers, and advocates to identify barriers and possible solutions for health care issues for persons who are homeless. The conference will offer opportunities to form partnerships to solve problems and will be followed by a series of more localized conferences to support and strengthen such partnerships in Fiscal Year 2001.

Finally, the Department fully concurs with the report's observation that findings from McKinney-funded programs must be transferred to mainstream programs. We have taken numerous steps that acknowledge McKinney funding as an emergency response and that mainstream programs must benefit from what we have learned from this response. The SAMHSA is currently collaborating with the public and assisted housing programs of the Department of Housing and Urban Development to use findings from a McKinney-funded demonstration of systems integration for homeless persons with mental illnesses to design a strategy of collaboration between mainstream housing and mental health providers at the local level. As another example, HCFA funded a diverse group of stakeholders from the Health Care for the Homeless program to discuss strategies for providing effective health care through Medicaid managed care programs to persons who are homeless. Subsequently, HCFA has facilitated increased opportunities to make States and health plans better understand the special needs of persons who are homeless. Finally, the Health Resources and Services Administration (HRSA) observes that while community health centers (CHCs) are largely autonomous, they are subject to program law, regulations, and expectations. The HRSA suggests that they could provide guidelines to CHCs on strategies to best meet the needs of homeless individuals. There currently is an expectation that CHCs be able to demonstrate that a significant percentage of their grant dollars are used to cover uncompensated care. Emphasis could be placed on persons most in need of services, or who face the most serious barriers to accessing needed health care.

GAO's Comments

1. We agree with HHS that outcomes for programs serving homeless people may be as successful as programs serving other special populations and that homeless people are not necessarily more exceptional than other special populations, such as the gravely disabled or chronically ill. However, our report simply highlights that homeless people—as with any population that faces special challenges—can be more difficult to serve than mainstream populations that do not face special challenges. As a result, performance measurement systems that compare the outcomes of hard-to-serve populations with those of other populations may put programs that focus on hard-to-serve populations at a relative disadvantage.

Related GAO Products

Homelessness: Grant Applicants' Characteristics and Views on the Supportive Housing Program (GAO/RCED-99-239, Aug. 12, 1999).

Homelessness: State and Local Efforts to Integrate and Evaluate Homeless Assistance Programs (GAO/RCED-99-178, June 29, 1999).

Homelessness: Coordination and Evaluation of Programs Are Essential (GAO/RCED-99-49, Feb. 26, 1999).

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