PENNSYLVANIA | 2016

MEDICAID SUPPORTIVE HOUSING SERVICES

crosswalk

CSH
The Source for Housing Solutions

About CSH

CSH transforms how communities use housing solutions to improve the lives of the most vulnerable people. We offer capital, expertise, information and innovation that allow our partners to use supportive housing to achieve stability, strength and success for the people in most need. CSH blends over 20 years of experience and dedication with a practical and entrepreneurial spirit, making us the source for housing solutions. CSH is an industry leader with national influence and deep connections in a growing number of local communities. We are headquartered in New York City with staff stationed in more than 20 locations around the country. Visit csh.org to learn how CSH has and can make a difference where you live.

Acknowledgements

The Pennsylvania Department of Human Services (DHS) assisted CSH, by reviewing the initial crosswalk and confirming and clarifying State Plan services. Staff from DHS's Office of Mental Health and Substance Abuse (OMHSAS) provided feedback and clarification based on OMHSAS specific services. Assistance was provided from DHS through phone consultation, written correspondence, and several in person meetings.

One of the DHS' highest priorities is housing. DHS is concentrating efforts on increasing access to affordable, integrated, and accessible housing for persons with disabilities and low- to extremely low-incomes. To ensure these individuals have the appropriate services to live successfully in the community, DHS applied for and was awarded technical assistance through the Centers for Medicare and Medicaid Services (CMS) Innovation Accelerator Program (IAP) which started in February and proceeded through April 2016. With the guidance provided through the CMS Information Bulletin and the technical assistance from IAP, DHS is currently developing a series of Medicaid Housing Related Services Crosswalks, similar to the Supportive Housing Services Medicaid Crosswalk developed by CSH. The DHS Crosswalks include the full scope of Pennsylvania's Medicaid State Plan and Waivers (1915 b and 1915 c) and are an informational tool that DHS will use to analyze what housing related services may be expanded and strengthened.

INTRODUCTION

In partnership with the Pennsylvania Health Access Network, the Housing Alliance of Pennsylvania, the Pennsylvania Health Law Project, and Project HOME, CSH conducted a Medicaid Supportive Housing Services Crosswalk. The Pennsylvania Medicaid Supportive Housing Services Crosswalk which includes a "cross-walk" or map of how Medicaid-eligible services align with supportive housing services is intended for healthcare and housing providers and advocates wanting to learn more about covered supportive housing services, advocate for Medicaid coverage of these services, and expand investment in supportive housing and provider capacity-building.

Supportive housing services include housing transition services, housing and tenancy sustaining services and care management support services. The positive impact that supportive housing and its services can have on an individual's use of preventive health care services, management of chronic diseases and appropriate use of healthcare resources is widely acknowledged by national leaders and supported by evidence-based research. Recognizing the positive impacts supportive housing can have, the Pennsylvania Medicaid Supportive Housing Services Crosswalk examines the extent to which supportive housing services may be considered eligible for coverage under Pennsylvania's Medicaid program and Pennsylvania's Medicaid Waivers. The report also provides recommendations for state leaders, healthcare and housing providers, and health advocates working to promote supportive housing and its positive impact on vulnerable individuals throughout the state.

This report consists of four parts:

- Part I – Background and definitions for supportive housing and Medicaid
- Part II – Key aspects of Pennsylvania's Medicaid State Plan and Waivers
- Part III – Supportive Housing Services Medicaid Crosswalk methodology and findings
- Part IV – CSH's recommendations for the steps Pennsylvania can take to maximize Medicaid to pay for supportive housing services

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The World Health Organization identifies housing as a social determinant of health, which means it is an underlying, contributing factor to health outcomes.

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I. Background and Definitions

In Pennsylvania, a small yet noteworthy group of residents have critical, unmet housing and healthcare needs. Many of these highly vulnerable individuals are living with multiple chronic health conditions and behavioral health challenges, including severe mental illness, opiate addiction and other substance use disorders. Most have extremely low incomes and many are unstably housed, homeless, and/or cycling through multiple social service systems and institutions. Despite their frequent use of public systems such as long-term care facilities, jails, shelters, and hospitals, these individuals are not receiving the level of care they need and therefore are not experiencing improved health outcomes. Instead, they experience expensive and often preventable institutionalization, a lack of access to primary care and a lack of integrated services addressing their co-occurring disorders and co-morbidities. While these residents represent a small percent of the total state population, their healthcare costs constitute a large and disproportionate percent of Pennsylvania's Medicaid expenditures.

A. Supportive Housing Services Crosswalk Definitions

Supportive housing combines affordable housing with intensive tenancy support services to help people who face the most complex challenges to live with stability, autonomy, and dignity. Research demonstrates that supportive housing provides housing stability, supports community integration, improves health outcomes, and reduces public system costs. Supportive housing is not affordable housing with resident services. It is a specific intervention that provides specialized, housing-based support services with low client-to-staff ratios (generally one-to-fifteen and not more than one-to-twenty-five). Supportive

Health & Housing: Sharon's Story

Sharon, a 51 year-old African American Philadelphian shared her story about the role of housing in her healthcare with Project HOME staff.

"I came from an abusive family and I felt as though I needed to leave so I was livin' on the streets since 13. Then I started usin' drugs at 13." Off and on for the next 35 years, Sharon lived on the street and couch surfed, and continued using drugs. Sharon says that she has been through a lot in her life, including being raped multiple times. "When we're out there on the streets on our own we fall prey to people and we do things just to survive."

It wasn't until Sharon got into permanent supportive housing that she was able to start fully addressing her healthcare, both physical and mental, for the first time in decades. Sharon is borderline diabetic, and has been diagnosed with depression, Bipolar Disorder, PTSD, and anxiety.

"When you go to the doctor and then you see what the drugs have done to you - your body, your insides – and then you start carin' about yourself. You know, you no longer want to live that life. It's really important for us to have healthcare."

Now, Sharon continues working on her personal goals while regularly seeing her doctors and staying on top of her healthcare. "I would have never known I was Bipolar. Being [in supportive housing] helped me be aware of my health so I know what I suffer with."

Sharon explains that housing and healthcare go hand-in-hand. "If you have housing that means you'll be stabilized and you can work on your healthcare or what's goin' on with you." And Sharon is doing just that.

housing units can be in scattered-site rent subsidized apartments, in single-site locations that have been developed or rehabilitated[1], and in integrated mixed-income buildings with a certain number of units set aside for supportive housing.

The housing in supportive housing is affordable and requires a lease. It is not time-limited or transitional. It is a platform from which tenants can engage in services, as they choose, with guidance from case managers. The core services in supportive housing are pre-tenancy (outreach, engagement, housing search, application assistance, and move-in assistance) and tenancy sustaining services (landlord relationship management, tenancy rights and responsibilities education, eviction prevention, crisis intervention, and subsidy program adherence) that help people access and remain in housing. In addition, supportive housing service providers link tenants to clinical primary and behavioral health care services. Finally, services such as counseling, peer supports, independent living skills, employment training, end of life planning and crisis supports are also often provided for supportive housing residents.

The homelessness response system fully embraces supportive housing as a best practice for ending chronic homelessness, but it does not have the resources to take this intervention to scale. A lack of sustainable services funding often delays the creation of new supportive housing units. Proper leverage of Medicaid reimbursement for these services could allow funders to reallocate their more flexible resources to housing related activities (rental assistance and capital costs) and create more supportive housing units.

Medicaid is public health insurance that pays for essential medical and medically-related services for people with low-incomes. Statutorily, Medicaid insurance cannot pay for room and board directly. Medicaid's ability to reimburse for services starts with a determination as to whether the services are medically necessary.

Medicaid State Plan

States and the federal government jointly finance the Medicaid program. The Centers for Medicare and Medicaid Services (CMS) oversee all state Medicaid plans. A Medicaid "State Plan" is the contract between that state and the federal government. It determines which services are covered and how much each entity will pay for the program. All state plans cover certain mandatory benefits as determined by federal statute. States and CMS can also

[1] It is important to note that supportive housing promotes independence and community integration. Supportive housing that utilizes a scattered-site or integrated model can be used to decrease segregation and support community integration for individuals living with disabilities.

agree to cover additional benefits designated as optional.[2] For example, the rehabilitative services option is an optional benefit that many states use to cover a broad range of recovery-oriented mental health and substance use disorder services. For CMS to approve optional benefits, states must meet CMS rules. For the rehabilitation[3] option, the service must meet the purposes of "reducing disability and restoring function.[4] " States looking to alter a current state plan to clarify the role of supportive housing in existing waivers can achieve this clarification with a state plan amendment.

Medicaid Waivers

States can also apply to CMS to amend or waive certain provisions in their state plans for specific populations by adopting state plan amendments and waivers. For example, in states facing the opioid epidemic, these states may benefit from creating a waiver on providing supportive housing and case management services to individuals with diagnosed opiate addiction or substance use disorders.

Waivers are commonly known by their federal statute section number. Some have particular applicability to supportive housing services. 1115 Medicaid waivers allow for state demonstration programs for new services, populations or payment structures, such as supportive housing services for individuals with substance use disorders. 1915 (c) Waivers and 1915 (i) state plan amendments help states target Home and Community Based Services (HCBS) for specific populations (seniors, individuals with severe or persistent mental illness, developmental disabilities, children with special health care needs, people living with traumatic brain injuries). These services are designed to serve people in their own homes and communities rather than in institutions. Pennsylvania has several 1915(c) Waivers, including the Aging Waiver,[5] COMMCARE Waiver,[6] and Independence Waiver,[7]

[2] For more detail on mandatory and optional Medicaid benefits - http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Medicaid-Benefits.html

[3] Medicaid distinguishes between rehabilitative services and habilitative services. Rehabilitative services must restore a previous level of functioning while habilitative services are designed to assist individuals in *acquiring*, retaining, and improving skills necessary to reside successfully in home and community-based settings. Habilitative services can be covered by Medicaid through a HCBS waiver or optional HCBS State Plan services. Habilitation is one of the Essential Health Benefits (EHB) that must be offered when a state adopts an "Alternative Benefit Plan" to provide coverage to newly eligible Medicaid beneficiaries beginning in 2014. States have flexibility in how they design and implement these benefits and plans, consistent with rules established by the Federal Government. The CMS Final Rule that includes EHB Requirements and other minimum standards can be found at https://www.federalregister.gov/articles/2013/07/15/2013-16271/medicaid-and-childrens-health-insurance-programs-essential-health-benefits-in-alternative-benefit#h-14.

[4] Wilkins, C., Burt, M., and Locke, G. (July 2014). A Primer on Using Medicaid for People Experiencing Chronic Homelessness and *Tenants in Permanent Supportive Housing*. Page 32. Available at: http://aspe.hhs.gov/daltcp/reports/2014/PSHPrimer.cfm.

[5] Pennsylvania 1915(c) Aging Waiver http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/c_216872.html

[6] Pennsylvania COMMCARE Waiver http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/c_216874.html

[7] Pennsylvania Independence Waiver http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/c_216875.html

among others. The Crosswalk confirms that some of these waivers include benefits needed by those living in supportive housing.

Medicaid reimbursement can be delivered in a variety of ways. States can reimburse providers directly for services or contract with managed care organizations (MCOs) to negotiate services and payment structures with providers. In some cases, MCOs also deliver services directly. States and MCOs establish agency licensing and credentialing requirements and staff qualifications that determine which providers can receive Medicaid reimbursement. Many MCOs aim to reimburse providers within 30 days of the provider submitting a claim.

II. Pennsylvania's State Medicaid Plan

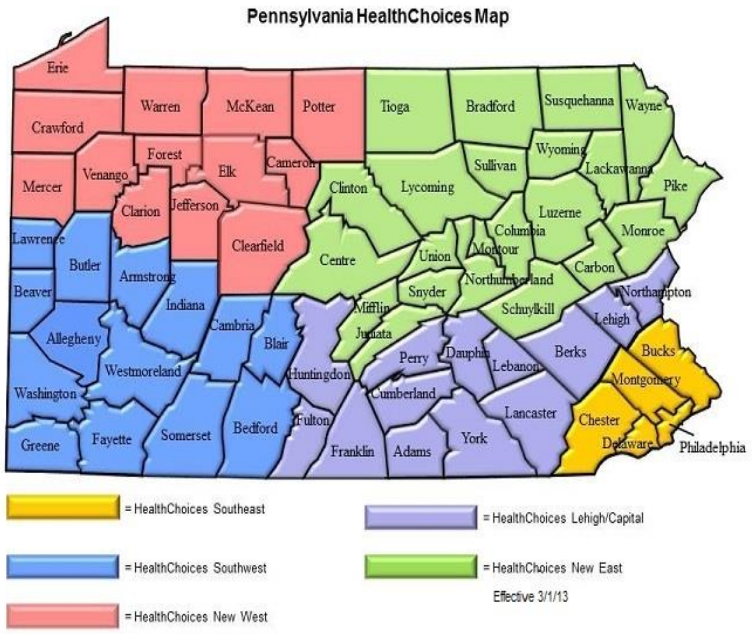
Pennsylvania began its Medicaid expansion in January 2015 and completed the transition to expansion coverage in September 2015. As a result, nearly all people with extremely low-incomes now qualify for Medicaid health insurance, known in Pennsylvania as Medical Assistance, which covers the standard benefits required by the federal government. Pennsylvania's Medical Assistance program has many authorities through which the state pays for services.

Because much of the State Plan addresses the needs of adults with serious mental illness, substance use disorders, and the behavioral health needs of youth under age 21, this reports also includes analysis of three waiver programs in order to include highly vulnerable individuals who are seniors or who are living with physical disabilities and/or traumatic brain injuries.

A. HealthChoices: Managed Care Delivering Physical Health Services

The HealthChoices Program is Pennsylvania's statewide mandatory Medicaid managed care program. Medical Assistance recipients can choose an in-network primary care medical provider and receive the regular Medicaid benefit package through their selected or assigned managed care organization. Pennsylvanians have a choice of four or five physical health focused managed care organizations (PH-MCOs) depending on the region of the state in which they reside. In Pennsylvania, behavioral health services are a "carve out" within the HealthChoices program, which allows for separate management of both physical health and behavioral health services. This means that behavioral health services were not included in the contracted services covered through physical health managed care organizations.

Figure 1: Pennsylvania HealthChoices Map, effective 3/1/13



B. Behavioral Health Services and Managed Care Service Delivery

Rather than automatically including behavioral health services to be managed through Physical HealthChoices contracts, the state granted counties the opportunity to manage the behavioral healthcare services in their communities. Many counties (individually and in groups) have HealthChoices contracts to deliver care and subcontract with a behavioral health managed care organization (BHMCO). These counties have direct contracts with the State to provide behavioral health services. In counties that chose not to manage the program, Pennsylvania's Office of Mental Health and Substance Abuse Services (OMHSAS) contracts directly with a BHMCO to manage service delivery. Additionally, behavioral health services may be delivered through the State's Fee-For-Service system under certain conditions.

Pennsylvania currently has five managed care organizations coordinating behavioral health services within the state. Four of these BHMCOs are operating in multiple counties. Unlike physical health MCOs who can operate simultaneously within the same region or county, each county has contracted with only one BHMCO to administer behavioral health services to all enrollees residing in that county, with no overlapping coverage.[8] The Department of Human Services website includes an updated listing of all HealthChoices Behavioral Health contracts and contract contact information.[9]

BHMCOs use the funds they receive from the county and state to negotiate contracts with appropriately credentialed behavioral health providers to deliver services. BHMCOs have flexibility in their reimbursement methods to providers, including negotiating reimbursement rates and frequency. BHMCOs can elect to cover approved supplemental benefits contracted with individual providers beyond the scope of services required by the State Plan. Substance use disorder (SUD) services are currently considered supplemental benefits. Approved supplemental services are intended to be recovery-oriented, evidence-based services that meet members' needs and are cost effective, however, because SUD services are optional supplemental benefits, there is the potential for inconsistency in both the range and quality of SUD services offered to Pennsylvanian's from county to county.

[8] Mental Health Association in Pennsylvania. "Roadmap to Care- county specific resources." http://www.mhapa.org/wp-content/uploads/2013/05/County-BHMCO.jpg

[9] Pennsylvania Department of Human Services, "Pennsylvania Medicaid Managed Care Organization (MCO) Directory, June 2016." http://www.dhs.pa.gov/cs/groups/webcontent/documents/communication/s_002108.pdf

C. Pennsylvania's 1915 Medicaid Waiver Authorities

There are three 1915 Waivers in Pennsylvania that most directly serve people who need supportive housing. These waivers are all HCBS waivers[10] that allow individuals to remain in their community and avoid unnecessary institutionalization in long-term care facilities.

1. **The COMMCARE Waiver** is authorized by a 1915(c) Waiver. The 1915(c) Waiver gives the state the authority to offer additional home and community based services to Medicaid beneficiaries with traumatic brain injuries so that they can live independently, outside of institutional care.

2. **The Independence Waiver** authorizes services for Medicaid beneficiaries who have a primary diagnosis of physical disability and wish to remain in their home or community even though they qualify for a clinical nursing facility level of care. This waiver provides the services these individuals need to remain successful and independent in their own homes and communities.

3. **The Aging Waiver** provides in-home, community based long-term care services for persons who are over age 60 and have elected to live in their home or community as an alternative to institutional care in a nursing facility, after having been determined eligible for clinical nursing facilities.

Community HealthChoices is a new initiative in Pennsylvania that will use MCOs to coordinate physical health care and long-term services and supports (LTSS) for older persons, persons with physical disabilities, and Pennsylvanians who are dually eligible for Medicare and Medicaid. Individuals that previously would not receive MCO services after selecting and applying for an HCBS waiver will now have the opportunity to have coordinated physical health care and long-term services and supports under managed care. Behavioral health services will still be coordinated through the existing HealthChoices Behavioral Health Program and its BHMCOs.

Following is an overview of key aspects of the Pennsylvania State Plan and Medicaid Waivers that most relate to supportive housing services.

[10] Explanation of Medicaid 1915 Home and Community Based Waivers - https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS-Roadmap/Resources/State-Federal-Relationships/State-Medicaid-Policies.html

III. Supportive Housing Services Crosswalk Findings

A. Supportive Housing Services Crosswalk Methodology

To determine the degree to which Medicaid currently pays for supportive housing services, CSH 'cross walked' the services provided in supportive housing with key provisions of the PA State Plan and relevant PA Medicaid waivers. CSH then reviewed the initial crosswalk findings with the PA DHS to confirm and clarify OMHSAS specific DHS State Plan services. Assistance was provided through phone consultation, written correspondence, and several in person meetings. CSH conducted provider interviews with six providers across the State. These interviews were conducted at the same time as the State Plan and State Medicaid Waiver analysis. Sections B, C, and D of the Crosswalk details CSH's analysis of alignment and gaps identified in the State Plan, the State Medicaid Waivers when compared to the services in supportive housing. Section D describes the degree to which supportive housing services are being covered in practice.

B. State Plan and State Medicaid Waiver Alignment

Supportive housing services covered by Medical Assistance

Pennsylvania Medical Assistance covers many of the services necessary for individuals who benefit most from supportive housing, particularly for those with severe mental illness and those who are eligible for HCBS Waiver services. It should be noted that many of the covered services mentioned in this report require that the consumer have a diagnosis of a severe or persistent mental illness or qualify for one of the waiver programs. Qualifying for a waiver program does not guarantee that an individual will receive services under the waiver, as waiver programs are not entitlement programs and often have waitlists.

Table 1: Related Services Currently Covered by PA Medical Assistance
Case Management and Service Coordination
Psychosocial Assessment
Service Plan Development
Referral to other services and programs
Crisis Intervention
Non-Emergency Brokered Medical Transportation to and from a Medicaid Service or Pharmacy
Medication Management through Medical Visits
Psychiatrist Services
Substance Abuse Counseling
Methadone Maintenance
HIV/AIDS services
Group and Family therapy
Peer Support Services (if diagnosed with SMI and meeting eligibility criteria)

Case management is a fundamental service needed by supportive housing residents. Pennsylvania Medical Assistance is uniquely positioned because it currently provides multiple levels of case management and service coordination to Medicaid beneficiaries, through targeted case management for individuals with SMI. Targeted Case Management services are offered in three levels of case

management (intensive case management; blended case management; and blended enhanced case management) through BHMCOs.

Peer support services (PSS) are another set of fundamental services critical to the success of supportive housing residents. PSS are services provided by individuals with lived experience with mental illness. These providers self-identify as "peers" and complete certification as behavioral health providers who support clients by sharing their own lived experiences. Peers are skilled navigators of complex health systems and PSS has been proven to produce positive outcomes for tenants in supportive housing. Pennsylvania offers a robust peer support provider training and certification program. Additionally, PSS can be provided by multiple provider types including those that bill through the Fee-For-Service system and those contracting with BHMCOs.

Service plan development is a process that can be as unique as each individual that is receiving services. It is important to note that for targeted case management services in Pennsylvania, a service plan is developed by a qualified case manager who is providing face-to-face management and coordination services. It should be developed in conjunction with the consumer and updated every six months. For waiver services, the service plan is developed by a service coordinator (SC) at an Independent Enrollment Broker. This SC is not the provider delivering the services. For supportive housing, the housing support plan should be developed with both the consumer and provider present.

C. Supportive housing services with potential for alignment

CSH has identified multiple supportive housing services that have the potential for coverage under the current State Plan, yet the certainty of this coverage remains vague due to state plan language that was not originally written to explicitly cover supportive housing services.

In June 2015, CMS issued a bulletin on supportive housing pre-tenancy and tenancy support services that federal Medicaid now considers reimbursable.[11] The informational bulletin outlines how states can go about making changes to their current Medicaid state plan and waivers to include these newly recognized supportive housing services. The clear language outlining supportive housing pre-tenancy and tenancy support services within the CMS bulletin offers a guide for states looking to promote best practices by clarifying which supportive housing services are covered in their state plans and waivers.

In Pennsylvania, many of these CMS defined pre-tenancy and tenancy support services have the potential for alignment. Table 1 below outlines the supportive housing service

[11] CMCS Informational Bulletin, "Coverage of Housing-Related Activities and Services for Individuals with Disabilities," June 26, 2015. https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-06-26-2015.pdf

and the corresponding behavioral health service that could potentially support Medicaid billing.

Part of the Crosswalk analysis included examining services provided under targeted case management for individuals with severe mental illness (SMI). One example of a potentially aligned service includes the housing support service plan. While the State Plan does not overtly mention housing service plans as covered, it does cover Individualized Service Plans (ISP) and treatment/service plans under case management and targeted case management for individuals with severe mental illness.[12,13] The State Plan does not exclude housing goals from being included in an individual's self-identified goal within their service plan, yet it does not specify inclusion of housing goals either. Therefore, if an individual with a behavioral health diagnosis of schizophrenia identifies remaining in her apartment as one of her recovery goals for her service plan, this client could work with her case manager to develop a housing supports service plan as a component of her case management treatment/service plan. The time then spent developing the housing supports service plan may be covered by Medical Assistance. This is because the service plan is a Medicaid covered service and the client identified housing as one of her goals.

In Pennsylvania, targeted case management for individuals with SMI is divided into two types of case management that both include the same services but at different levels of intensity: Intensive Case Management (ICM) and Resource Coordination (RC). Some County Mental Health and Intellectual Disabilities Administrators have contracted with BHMCOs to provide a blended model of case management (Blended Case Management) where individuals can remain with the same case manager or case management team as they move between the tiered system of ICM and RC as their needs change. More information can be found in the Office of Mental Health and Substance Abuse Services bulletin OMHSAS-10-03 issued in June 2010.

The housing service plan is an example of "potential alignment" with the State Plan, because had this client not specified housing as a personal goal for her service plan, the development of a housing service plan would not be covered by Medical Assistance. Greater clarity is needed in the State Plan and relevant waivers to ensure that tenancy support services

[12] Targeted Case Management (TCM) for individuals with SMI is defined in Pennsylvania's code Chapter 1247.2 as, "Services which provide targeted Medicaid recipients with access to comprehensive medical and social services to encourage the cost effective use of medical and community resources, promoting the well-being of the recipient while ensuring the recipient's freedom of choice." http://www.pacode.com/secure/data/055/chapter1247/s1247.2.html
[13] Office of Mental Health and Substance Abuse Services, Bulletin OMHSAS-10-03. http://www.wpic.pitt.edu/oerp/CMTrain/Blended%20Bulletin%202010.pdf

related to an individual's health and recovery goals are covered under case management services.

Currently, if an auditor determines during a quality review that they do not believe housing to be a medically necessary goal the claim could also be denied. Without written clarification from the State or BHMCO regarding details of covered supportive housing services the coverage of most of CMS' defined "pre-tenancy and tenancy sustaining supports" remain ambiguous at best.

Table 2: Supportive Housing Services with Potential for Medicaid Coverage under PA Medical Assistance

Supportive Housing Service	Comparable Medicaid-reimbursable Service with Potential for Alignment
Assessment of housing preferences and barriers related to tenancy	Psychosocial Assessment under Mental Health Targeted Case Management (MH-TCM)
Housing Service Plan	Service Plan Development under MH-TCM
Identification of resources to cover moving and start-up expenses	Referral to other services and programs under MH-TCM
Assistance with move-in arrangements	Referral to other services and programs under MH-TCM
Assistance with collecting required documentation (i.e. birth certificate, IDs, credit history)	Resource coordination under Case Management and Service Coordination
Assistance with housing search and housing applications	Resource coordination under Case Management and Service Coordination
Communication Skills	"Mentoring, individual advocacy and social network" under Peer Support Services (PSS) if diagnosed with SMI and have PSS referral
Early identification/intervention for behaviors that could jeopardize housing	Psychosocial Assessment, Service Plan Development and Psychiatrist Services
Coaching on developing and maintaining relationships with landlord/property manager/neighbors	"Mentoring, individual advocacy and social network" under Peer Support Services (PSS) if diagnosed with SMI and have PSS referral or

	Can assist a client in developing skills to resolve problems-"problem resolution" under Intensive Case Management
Assistance resolving disputes with landlords, property management, and neighbors	"Problem Resolution" under Intensive Case Management if provider is assisting client in resolving disputes. The focus must be on assisting the client to recover skills in resolving disputes. ICM cannot resolve disputes on behalf of the client.
Advocacy/linkage with community resources to prevent eviction/sustain successful tenancy	Peer Support Services can provide linkage and advocacy. MH-TCM can provide linkage, but not advocacy.
Development of housing support crisis plan	Service Plan Development as a part of MH-TCM

D. State Plan Gaps

Some supportive housing services do not align with the current Pennsylvania State Plan. These *gaps* in service are highlighted below and are also addressed in the Recommendations section at the end of this report.

The following key gaps exist in the provision of the following supportive housing services.

1. Gaps in Populations Served

Currently, individuals who have a primary diagnosis of Substance Use Disorder (SUD) are not covered for supportive housing services under the PA Medicaid State Plan. In Pennsylvania, the CDC reported a significant increase in the number of overdose deaths counted statewide.[14] These deaths are occurring in the homeless community in Philadelphia, as street outreach workers and the homeless death review team report encountering increasing numbers of individuals with opioid-related addictions. The gap in Medicaid coverage and need for supportive housing services for homeless individuals with SUDs is a serious concern among providers and advocates.

Mental Health Targeted Case Management (MH-TCM) and Peer Support Services (PSS) offer the potential to cover many of the tenancy support services listed above, yet these services are limited to individuals with primary diagnoses of severe mental illness and demonstrated medical necessity. As such, individuals who are homeless with multiple

[14] CDC. Morbidity and Mortality Weekly Report, Increases in Drug and Opioid Overdose Deaths — United States, 2000–2014. January 1, 2016 / 64(50);1378-82, http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6450a3.htm?s_cid=mm6450a3_w

unmanaged chronic medical conditions (such as diabetes or COPD) or with a primary diagnosis of a substance use disorder (SUD) may not be considered eligible for TCM or PSS. For example, an individual who is homeless with an opioid addiction and does not have a behavioral health diagnosis of schizophrenia, major mood disorder, psychotic disorder NOS or borderline personality disorder would not be eligible to receive peer support services.[15]

2. Gaps in Tenancy Support Services

The gaps identified below are services that are a part of the package of evidence-based practices for supporting individuals to live successfully in supportive housing yet are not explicitly included as covered services in the PA Medicaid State Plan.

- Assistance with collecting required documentation
- Assessment of housing preferences and barriers related to tenancy
- Assistance with housing search and housing applications
- Identification of resources to cover moving and start-up expenses
- Ensuring housing unit is safe and ready for move-in
- Assistance with move-in arrangements
- New tenant orientation/move-in assistance
- Tenant's rights education/introduction to tenants council
- Education/training on tenant and landlord rights/responsibilities
- Ongoing training and support with activities related to household management and healthy tenant habits
- Coaching on developing and maintaining relationships with landlord/property manager/neighbors
- Assistance resolving disputes with landlords, property management, and neighbors
- Assistance with housing recertification
- Assistance with acquiring furnishings

It should be noted that many of the covered services listed here require that the consumer have a diagnosis of a severe mental illness or qualify for one of the waiver programs. Many individuals covered by PA Medical Assistance experiencing homelessness or housing instability do not meet the Nursing Facility Clinically Eligible standard required by waivers, yet would benefit significantly from supportive housing services.

3. Gaps in Covered Case Management Services

- Nutritional services
- Transportation to non-medical appointments
- Opportunities for tenants to volunteer
- Emergency financial assistance
- Personal financial management and budgeting
- Credit counseling

[15] Magellan Compliance Notebook. http://magellanofpa.com/media/1061581/compliance_alert_may_2015.pdf

- Representative payee
- Job skills training
- Job readiness training — resumes, interviewing skills

The services listed above are not covered by Medicaid under Mental Health Targeted Case Management (MH-TCM) services, however, an MH-TCM case manager can provide assistance in *linking* an individual to services, as available, if the services are in the individuals' service plan. Similarly, a Peer Support Services provider can connect an individual with volunteer opportunities but cannot accompany the individual to the volunteer opportunity.

4. Gaps in Access to Waiver Services

For providers serving individuals who are eligible for a Waiver program, opportunity exists, however because waiver programs are not entitlement programs, a waiver program cannot guarantee that an individual in need of services will receive services under the waiver. Additionally, waiver programs require a level of functional barrier to qualify for services known as the Nursing Facility Clinically Eligible standard. Many individuals covered by PA Medical Assistance experiencing homelessness or housing instability do not meet the Nursing Facility Clinically Eligible standard, yet would benefit significantly from supportive housing services.

D. Interviews with Supportive Housing Service Providers

The following section builds upon the analysis of covered supportive housing services and gaps in coverage in the Plan itself and presents identified gaps in practice. CSH conducted interviews with six supportive housing providers across Pennsylvania to understand the array of services that supportive housing providers are currently offering to tenants, regardless of the funding source. CSH also surveyed these same providers about their understanding of Medicaid reimbursement of supportive housing services. The information gained during the provider interviews is valuable because it highlights the valuable services supportive housing providers are currently offering tenants without Medicaid reimbursement, either because those services are not currently covered in the State Plan or because providers do not perceive them as Medicaid reimbursable services. This provider interview section included in the Crosswalk Report can be helpful for advocates and community leaders in support of the CMS recommended covered services for pre-tenancy and tenancy support services as well as those looking to expand provider education of the Medicaid State Plan.

5. Provider Perceptions of Medicaid Coverage for Supportive Housing Services

Interviews included questions on perceptions of PA Medical Assistance coverage for over 100 services within 10 categories:

1. Pre-tenancy supports
2. Tenancy-sustaining supports
3. Services plan development
4. Intake & assessment services
5. Referral, monitoring referrals and follow-up
6. Entitlement assistance and benefit counseling
7. Outreach and in-reach
8. Independent living skills training
9. Support Groups
10. Re-engagement

Provider interviews included a series of questions around provider perceptions of PA Medical Assistance coverage for over 100 services within 13 service categories. Providers were interviewed from across the state of Pennsylvania and representing multiple regions of the State. Interview questions examined providers understanding of the Pennsylvania Medicaid State Plan and its coverage of services related to supportive housing. Not all of the providers interviewed had experience with billing Medicaid. Those who had experience billing Medicaid were not all current billers or currently contracting with BHMCOs. An assessment of supportive housing providers' perceptions of covered supportive housing services (Table 2) helps to inform advocates and community leaders of areas for provider education and training about currently covered services.

Table 2: Divergence in Provider Perceived Covered Services When Compared to PA State Plan

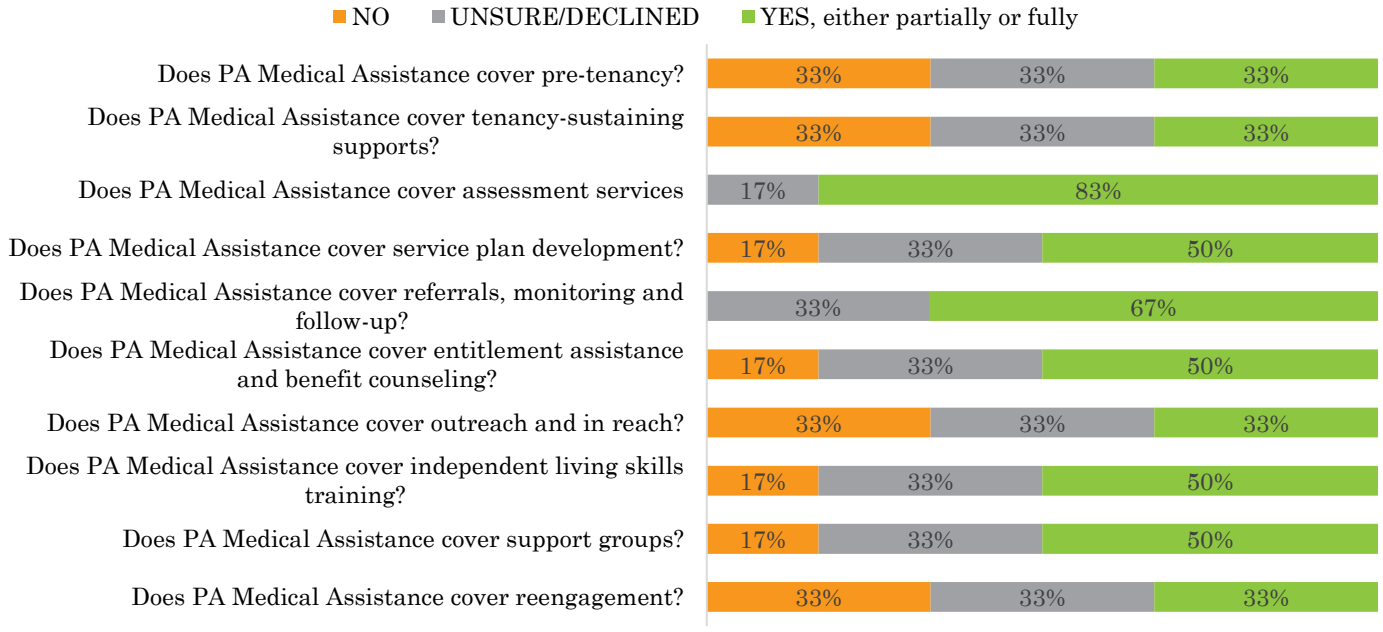
Service	Provider Perception	Current State Plan Reality
Domestic violence intervention	Uncertainty on required diagnoses for crisis intervention and safety planning.	Safety planning and crisis intervention covered for targeted case management with diagnosis of serious mental illness, serious emotional disturbances/medical necessity.
Support groups	Uncertainty around types of billable substance abuse and peer led groups.	Narcotics Anonymous and Alcoholics Anonymous groups are not covered, nor are support groups covered under MH-TCM. Therapy groups for are billable under Mobile Mental Health Treatment services when medically necessary, in each group member's service plan, and with a staff client ratio of 1:10.
Discharge planning	Uncertainty around billing for hospital discharge planning team meetings.	MH-TCM may bill for services to individuals in a psychiatric unit in general hospitals during the last 30 days prior to discharge. If in a medical facility (not psychiatric) of a general hospital, MH-TCM may bill one contact per week for 8 weeks beginning on the date of admission as long as services don't duplicate or replace the responsibilities of the inpatient setting and the individual is discharged to the community.

More than half of the supportive housing providers interviewed reported that they did not believe *or* were unsure if the following services were covered by Medicaid in Pennsylvania's State Plan.

- Transportation
- Outreach and in-reach
- Re-engagement
- Pre-tenancy supports
- Tenancy-sustaining supports

The uncertainty among providers in how to interpret state plan coverage for supportive housing services (shown in Figure 1), as well uncertainty around how to document these services, highlights the need for clarity and education regarding supportive housing services. This clarity is particularly relevant following the CMS Informational Bulletin on supportive housing services released in 2015.

Figure 1: Provider Perceptions of PA Medical Assistance Coverage for Supportive Housing Services



The variance in provider responses also highlights the need for additional provider education on PA Medical Assistance, the processes for becoming a provider of Medicaid-covered services and contracting with managed care organizations within Pennsylvania.

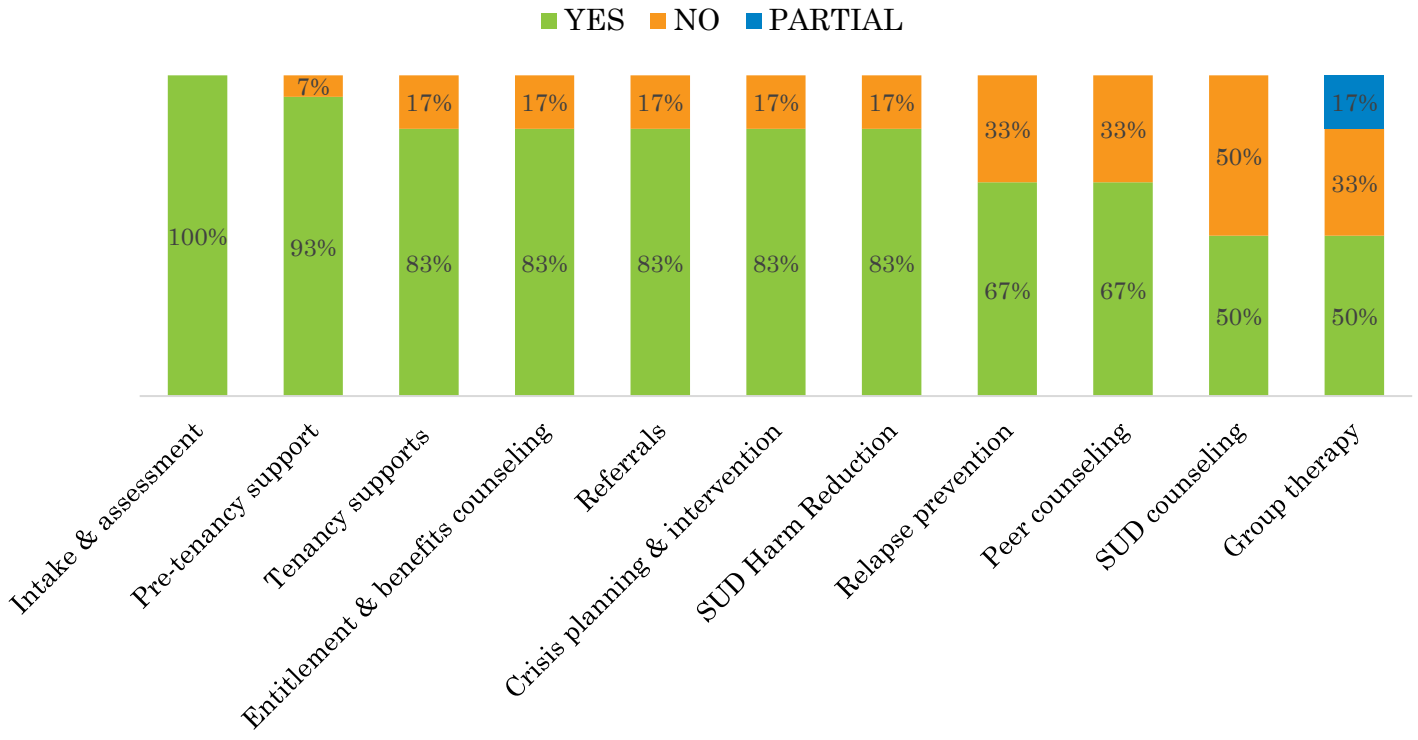
The majority of the services providers identified as being covered were services designated for individuals with serious mental illness or demonstrated serious emotional disturbance

with medical necessity. These perceptions were consistent with covered services in the state plan for individuals under blended case management, intensive case management and resource coordination. Providers interviewed for the Crosswalk noted that medical necessity and diagnoses must be demonstrated in order for providers to bill Medicaid for these services and these services are not available for individuals with a primary diagnosis of Substance Use Disorder.

6. Array of Services Delivered by Supportive Housing Service Providers

The majority of supportive housing providers interviewed provided the full range of pre-tenancy and tenancy-sustaining services (93% and 83% respectively). The details of the services provided by supportive housing providers interviewed are included in Figure 2.

Figure 2: Services Currently Provided by PA Supportive Housing Providers



Interviews with providers concluded that providers who responded "Partial" or "No" to providing the full range of supportive housing services are interested in providing additional supportive housing services should funding for these services become available through PA Medical Assistance.

7. Provider Identified Gaps in Covered Services and Reimbursement

This section includes provider comments about services they understand are covered by Medicaid but for which reimbursement levels do not align with the amount of time needed to deliver the services or the staffing needs for quality services.

a) Payment structures for targeted case management groups

Multiple providers shared concerns that the current payment structure for targeted case management groups dis-incentivizes providing group sessions. One provider shared that a one hour group is billed at the same rate as a one hour individual session. If five clients attend the group, the billed amount would be the same as if three people attend or if two people attend. Additionally, if a case manager met with all five people separately they could bill for five one hour segments. By only reimbursing for one client's time at the group, creating and maintaining steady attendance at groups is not incentivized.

One provider shared that peers and psychiatrists providing a group under targeted case management could not bill. This provider therefore always has a peer and another staff member present at groups so that the other staff member can bill, yet again this devalues the peer's time spent with clients in groups.

b) Supportive housing services for tenants with substance use disorders

One provider shared that they would like to provide an intensive case management level of care to more high need clients that do not currently qualify for ACT because they do not have serious and persistent mental illness. The provider offered multiple examples of highly vulnerable chronically homeless individuals who had a primary diagnosis of substance use disorder and multiple unmanaged chronic physical health challenges who would benefit from supportive housing and targeted case management. This provider noted that the variation in substance use disorder (SUD) treatment services (as supplemental services) across counties remains a concern and noted that clarification from the state is needed on the effectiveness of targeted case management and supportive housing services for individuals with a primary diagnosis of SUD.

Another provider shared the example that their agency frequently serves individuals who have diagnosed with substance use disorders yet who most likely have undiagnosed mental illness. It is unethical for a provider to make a mental health diagnosis when an individual is intoxicated, suspected to be under the influence of a drug, or has reported using substances just prior to the assessment. Because of this, many individuals who may, in fact, suffer from mental illness or emotional dysregulation may not have a mental health diagnosis that would qualify them for case management services despite their need of case management and supportive housing.

c) Lack of coverage for telephonic services

Supportive housing providers who serve people over large geographic distances reported wanting to provide telephonic services, but some believe that direct supportive case management services delivered virtually are not covered because they are not performed face-to-face.

Additionally, providers shared that referrals are dis-incentivized because often the receiving provider prefers a phone call referral, email referral or in some cases a fax. Only face to face collateral visits were perceived billable. If a provider is sitting with the client in person, modeling how to make a referral phone call and prompting the client to participate in the call, then the call is considered billable. Providers shared that often with long hold times, clients with serious mental illness and emotional disturbances are not able to tolerate these calls- yet this does not negate the importance and need for the referral service.

d) Challenges in capturing cost-savings where they are produced

One provider shared concern over how cost savings produced by excellent targeted case management and supportive housing might not be reinvested into supportive housing and case management services. This provider noted that savings would be realized through reduced hospital emergency room and in-patient use along with reduced nursing home stays, however, this provider feared that resources saved for the physical health managed care organizations may not be directed back into reimbursing supportive housing services or case management for substance use disorders.

8. Non-Medicaid Fund Sources Identified to Serve People with High Needs

All providers interviewed reported that they use non-Medicaid funds to support Medicaid clients for some or all of the services they provide. Following are a list of funding sources for supportive housing capital expenses, operating expenses and services mentioned:

- Federal Department of Housing and Urban Development Support
- Project-based housing choice vouchers
- Homeless Continuum of Care funding
- Federal Substance Abuse and Mental Health Services Administration Support
- State of Pennsylvania Support
- Agency budgets and fundraising (private grants and individual donors)

IV. CSH RECOMMENDATIONS

The state of Pennsylvania is making strides to create a system of care that meets the health needs of the whole person. Some of these changes are within the Medicaid State Plan (such as Medicaid expansion and newly covered inpatient and outpatient drug and alcohol services) while others are added to the list of possible supplemental benefits that primary health MCOs and BHMCOs can offer. In its most recent HealthChoices Physical Health Agreement effective January 2015, Exhibit U,[16] the Commonwealth of Pennsylvania clarified that certain mental health and drug and alcohol related services were not included in the current Medicaid State Plan or included in the capitated, in-plan benefit package, but proposed that BHMCOs could choose to provide approved supplemental services, including "targeted drug and alcohol case management" and "assistance in obtaining and retaining housing, employment, and income support services to meet basic needs" as a component of Assertive Community Treatment and Community Treatment Team services.

Following the completion of the Pennsylvania Supportive Housing Medicaid Crosswalk research, below are CSH recommendations for the Commonwealth of Pennsylvania, its providers and advocates.

Define and cover supportive housing services using CMS guidelines from the June 26, 2015 CMS Informational Bulletin.

Supportive Housing Services could be explicitly included in the negotiated rates the Commonwealth develops with counties and BHMCOs through the capitated, in-plan benefit package. Supportive Housing Services could also be included in a unique Supportive Housing Services benefit through a waiver that, similar to the Peer Support Services benefit, permits both Fee-For-Service and BHMCO reimbursement. This benefit would, like Peer Support Services, have its own certification process, allowing supportive housing service providers outside of the behavioral health targeted case management provider community to become certified and begin billing Medicaid for supportive housing services. Additionally, new guidance from CMS, including the Informational Bulletin, provides the State with an opportunity to fully review and realign its Medicaid State Plan to include recent CMS guidance.

Cover and expand supportive housing and case management services in State Plan to include individuals with substance use disorders.

With the severity of the opioid epidemic in Pennsylvania, and the proven effectiveness of supportive housing as an appropriate platform for providing addiction treatment services, a Supportive Housing Services benefit should target not only individuals with severe mental

[16] HealthChoices Agreement effective January 1, 2015, Exhibit U, Behavioral Health Services, pages U1, U2 (194-195). http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/p_040150.pdf

illness, but also individuals who are chronically homeless with substance use disorders or drug-related criminal histories, multiple chronic health conditions or a single chronic health disorder, if severely unmanaged and causing frequent hospitalizations. This benefit should not be limited to a supplemental service that is optional for BHMCOs. Rather, like Peer Support Services, it should be a required best practice benefit that addresses the social determinants of health and whole person in the State's contracts with BHMCOs.

The continuum of treatment options for individuals with substance use disorders must be expanded to include those that are homeless and actively using. This recommendation aligns with the goals of the newly established Pennsylvania Opioid Use Disorder Centers of Excellence. These centers are hubs that coordinate care for Medicaid recipients with opioid use disorders and provide team-based, "whole person" focused treatment, integrating physical and behavioral healthcare and linking patients with community resources through a care team. Funding supportive housing services strengthens these efforts. Supportive housing services can improve the integration of behavioral and physical health care services and promote collaboration between treatment providers and homeless service providers. Integration can be accomplished through a waiver that carves out supportive housing services for individuals with substance use disorders that are actively using, experiencing homelessness, and cycling in and out of emergency and crisis service systems (jails, prisons, shelters, hospitals, and detox facilities).

Build capacity in the Medicaid delivery system to support the integration of supportive housing services into the whole-person model of care.

Managed care organizations, including PH-MCOs, BHMCOs, and the soon to be developed Community Health Choices (CHC-MCOs) should be informed of the housing services available for Medicaid clients and should partner with the community-based agencies providing housing and supporting housing services in their communities. Supportive Housing Services provide integrated care for the whole-person as care coordination involves all crisis service systems, including emergency services, primary and behavioral health care, housing and homeless system services and addiction treatment services. Primary and behavioral health providers currently contracting with managed care should also receive training on the housing services available for Medicaid clients and should be supported to further coordinate care with supportive housing service providers.

Build capacity for the whole-person system of care by promoting training and technical assistance for supportive housing providers to bill Medicaid.

It is recommended that managed care and administrative organizations support and/or provide Medicaid training to supportive housing service providers. These agencies can play an important role in helping providers understand the structure and services of PH-MCOs,

BHMCOs and LTSS case management agencies (soon to be CHC-MCOs). Managed care and administrative care organizations can: 1) educate and plan with supportive housing providers on how to partner together to assist clients in achieving housing stability. Stakeholders should engage in cross-system learning to provide better care and better outcomes. 2) Provide an explanation of Medicaid covered benefits, those benefits not covered, and opportunities to partner with managed care organizations (Physical Health, Behavioral Health and Community HealthChoices) and other health services providers to improve housing services delivery and financing. 3) Support and promote training and technical assistance for quality supportive housing service providers to have the tools they need to: contract with managed care organizations; become Medicaid billing agencies; and better integrate services.

Encourage counties to redirect cost savings back to quality supportive housing services and housing systems.

National data and evaluations from around the country have demonstrated that supportive housing can lead to cost savings within the healthcare system. Cost savings have occurred as stable housing and support services contribute to reductions in emergency department visits, overnight hospital stays and days spent in long-term care facilities. A state-wide analysis of Medicaid claims data for individuals who are homeless and frequent users of high-cost emergency services offers the potential for Pennsylvania to better understand the cost savings potential supportive housing services could create.

Nationally, savings created by supportive housing are most commonly realized by both the physical health managed care organizations and behavioral health managed care organizations. Some states and managed care organizations are choosing to direct cost savings back into supportive housing services and housing subsidies as they find that this redirection allows them to pay for the right level of care, at the right time and place. Should Pennsylvania choose to create a supportive housing services benefit, the State should simultaneously encourage counties to reinvest cost savings into their County Housing Plan to provide additional supportive housing rental subsidies and supportive housing services that meet the Dimensions of Quality[17] Supportive Housing standards.

[17] For more information on the CSH Dimensions of Quality Supportive Housing and national certification of Quality Supportive Housing, visit: http://www.csh.org/certification