

NORTH DAKOTA | 2016

MEDICAID SUPPORTIVE HOUSING SERVICES

crosswalk

TENANT PROFILE REPORT



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 25 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.

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INTRODUCTION

The North Dakota Department of Human Services (DHS) participated in a national technical assistance initiative led by the Centers for Medicare and Medicaid Services (CMS) to conduct a Medicaid Supportive Housing Services Crosswalk. The Crosswalk examined the extent to which North Dakota’s Medicaid program covers supportive housing services for adults with significant housing and service needs. Supportive housing services include housing transition services (pre-tenancy support), tenancy sustaining services and care coordination.

Upon completion of the technical analysis of the State’s Medicaid Plan and authorities, DHS shared its findings with CSH and the Grand Forks Housing Authority (GFHA). CSH is working with GFHA and an extensive array of stakeholders in North Dakota to identify opportunities to use Medicaid funds to pay for permanent supportive housing services. CSH further analyzed DHS’s Crosswalk in order to provide the following summary of findings and recommendations to the State for next steps.

This Crosswalk examines the State’s Medicaid programs serving adults who would benefit most from supportive housing services, therefore it specifically focuses on targeted case management for individuals with serious mental illness and two North Dakota Medicaid waivers designed to assist adults living with disabilities: the Home and Community Based Services (HCBS) Waiver, commonly referred to as the Aging and Disabilities Waiver, and the HCBS Waiver for individuals with intellectual and developmental disabilities, often referred to as the Traditional DD Waiver.

This report consists of four parts:

- Part One –Background and definitions for supportive housing and Medicaid.
- Part Two – Brief overview of key aspects of the State’s Medicaid program and the estimated supportive housing needs in North Dakota.
- Part Three – Overview of key areas of alignment and gaps in the Crosswalk of services currently covered by Medicaid, presented through supportive housing tenant profiles.
- Part Four – CSH’s recommendations for the steps North Dakota can take to maximize Medicaid to pay for supportive housing services.

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 North Dakota, 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, substance use disorders and chronic conditions faced by North Dakotans who are aging or living with disabilities. 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 to a disproportionate percent of North Dakota’s expenditures.

A. Supportive Housing

Supportive housing combines affordable housing with intensive tenancy support services and care coordination to help people who face the most complex challenges to live with stability, autonomy, and dignity. Research demonstrates that supportive housing provides housing stability, improves health outcomes, and reduces public system costs. Supportive housing is not affordable housing with resident services. It is a specific intervention that employs principles of harm reduction and consumer choice in all service delivery, and it provides specialized, housing-based tenant support services with low staff-to-client ratios (generally one-to-ten or fifteen).

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 staff. 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 routinely provided for supportive housing residents.

The homelessness response system fully embraces supportive housing as a best practice for ending homelessness for those with the most need, 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. Supportive housing service providers, who either do not bill Medicaid or are not maximizing their

Medicaid billing, use a significant amount of resources that could pay for housing or non-Medicaid eligible services to stretch dollars further and create enough supportive housing to meet the need. Proper Medicaid reimbursement for services can allow providers to reallocate their more flexible resources to housing related activities (rental assistance and capital costs) and create more supportive housing units.

B. Medicaid

Medicaid, often referred to as Medical Assistance, 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.

C. 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 that 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 agree to cover additional benefits designated as 'optional' in federal statute.¹ For example, Medicaid's rehabilitative services option is an optional benefit that states use to cover a fairly 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 rehabilitation² option, the service must meet the purposes of "reducing disability and restoring function."³ Many states use this optional rehabilitative service to provide outpatient psychosocial rehabilitation services for individuals with serious mental illness and/or substance use disorders. However, in North Dakota this service is currently only provided for in-patient treatment at the North Dakota State Hospital.⁴

D. Medicaid Waivers

States can apply to CMS to amend or waive certain provisions in the state plan for specific populations by adopting state plan amendments and waivers. These authorities 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. 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,

¹ For more detail on mandatory and optional Medicaid benefits - <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Medicaid-Benefits.html>

² Medicaid distinguishes between rehabilitative and habilitative services. Rehabilitative services must "involve the treatment or *remediation* of a condition that results in an individual's loss of functioning," while habilitative services assist individuals in *acquiring*, retaining, and improving the self-help, socialization, and adaptive 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 that must be offered when a state adopts an "Alternative Benefit Plan" to provide coverage to people who are newly eligible for Medicaid beginning in 2014. On July 15, 2013, HHS and CMS issued a Final Rule that includes requirements to ensure that Medicaid benefit packages include Essential Health Benefits and meet certain other minimum standards. This Final Rule 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>.

³ 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>.

⁴ North Dakota Department of Human Services, North Dakota State Hospital Services, Adult Psychiatric Services. <https://www.nd.gov/dhs/locations/statehospital/services.html>

developmental disabilities, children with special health care needs, and people living with traumatic brain injuries). These services are designed to serve people in their own homes and communities rather than in institutions.

E. Medicaid Reimbursement

Reimbursement for Medicaid services 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. NORTH DAKOTA MEDICAID AND THE MEDICAID STATE PLAN

Beginning in October 2013, low-income adults in North Dakota (with income at or below 138% of the federal poverty level) were first granted access to enroll in Medicaid through Medicaid expansion. Medicaid expansion has had a significant impact on North Dakota residents, as it expanded eligibility to an estimated 35,000 low income adults, many of whom were previously uninsured, to receive covered preventive and primary health care services, among other services.⁵ By 2016, total Medicaid and Children's Health Insurance Program enrollment had increased by 28 percent, according to the U.S. Census, to cover nearly 89,500 residents. Of these Medicaid beneficiaries, some are experiencing homelessness and/or living with substance use disorders, chronic health conditions, and undiagnosed mental illness. Newly eligible for Medicaid services, many of these individuals who are experiencing homeless or housing instability are also in need of supportive housing services.

This Crosswalk report includes a review of North Dakota's Medicaid State Plan and its State Plan Amendments (SPAs), the 1915c Medicaid Waiver for Home and Community-Based Services (commonly called the Aging and Disabilities Waiver) and the Traditional IID/DD Home and Community Based Services Waiver (commonly called the Traditional DD Waiver). These authorities allow for the provision of services for highly vulnerable individuals who are aging and/or living with serious mental illness or behavioral health conditions, intellectual, developmental, or physical disabilities.

A. Managed Care in North Dakota

North Dakota DHS has contracted with the non-profit managed care organization Sanford Health Plan to manage Medicaid benefits and care for newly enrolled individuals who became eligible through Medicaid expansion. The Department has set up a payment contract with Sanford to contract with provider organizations including Rural Health Centers, Federally Qualified Health Centers, Indian Health Services and individual providers to offer Medicaid benefit services to North Dakota residents.⁶

It is important to note that treatment for behavioral health such as targeted case management, substance use disorder treatment, and mental health counseling are provided primarily in office based settings through Regional Human Service Centers.

⁵ North Dakota Medicaid. <https://www.healthinsurance.org/north-dakota-medicaid/>

⁶ <https://www.sanfordhealthplan.org/shopforhealthinsurance/medicaid/ndmedicaidexpansion/>

B. Fee for Service Reimbursement in North Dakota

In addition to managed care, which often reimburses through a case rate (i.e. a set dollar amount per enrolled client per day/month), North Dakota also operates a fee for service reimbursement system for some providers of HCBS Waiver services, including Adult Day Health services, Homemaker services, Financial Management services, and Infant Development services, among other fee for service programs.

Fee for service payment is based on the type of service provided and the duration of the service time. It is often calculated with a unit payment based on 15 minutes of service.

C. North Dakota's Medicaid Waiver Authorities

There are two 1915(c) waivers in North Dakota that most directly serve adults who need supportive housing. The first is the Home and Community Based Services waiver,⁷ often referred to as the Aging and Disabilities Waiver, which allows individuals to remain in their own home and community and avoid unnecessary institutionalization in long-term care facilities. Additionally, North Dakota has a separate 1915(c) waiver for Home and Community Based Services for individuals with intellectual disabilities and cognitive impairment, known as the Traditional Individuals with Intellectual Disabilities and Developmental Disabilities (IID/DD) Home and Community Based Services (HCBS) Waiver.

D. Non-Medicaid Funding for Mental Health and Substance Use Disorder Treatment

The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) awarded North Dakota DHS with a block grant for substance abuse prevention and treatment and community mental health services.⁸ Additional state funding was appropriated from general funds during 2016 for a Substance Use Disorder Voucher for substance use disorder treatment services.⁹ These services are intended to supplement Medicaid, Medicare, and private insurance benefits.

III. SUPPORTIVE HOUSING SERVICES CROSSWALK FINDINGS

To determine the degree to which Medicaid currently pays for supportive housing services, CSH worked with DHS staff to combine multiple crosswalks that staff members had completed through the Centers for Medicare and Medicaid Innovation Accelerator Program, a national technical assistance initiative. CSH then used these crosswalk findings to create tenant profiles depicting the opportunities and barriers to Medicaid services that North Dakotans may face on their recovery journey.

A. Crosswalk Alignment and Gaps

The chart that follows depicts pre-tenancy, tenancy sustaining, and care coordination services essential to providing high quality supportive housing and illustrates their alignment with the current North Dakota

⁷ 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>

⁸ North Dakota Uniform Application FY 2016/2017 State Behavioral Health Assessment and Plan. <https://www.nd.gov/dhs/info/pubs/docs/mhsa/draft-2016-2017-block-grant-mini-application.pdf>

⁹ North Dakota Department of Human Services. Substance Use Disorder Voucher Guidance, Version II. September 2, 2016. <http://nd.gov/dhs/info/pubs/docs/mhsa/sud-voucher-guidance-version2-9-2-16.pdf>

Medicaid program¹⁰. Services that align with North Dakota’s covered benefits and can be accessed without barriers are symbolized using the “√” symbol. Services that align on paper but have barriers to care in practice are symbolized using the approximation symbol “≈”. Services provided by case managers that are not formally assessed, not formally offered, or have multiple barriers in practice are symbolized with “~”. Services that are not covered are left blank.

SYMBOLS USED √ : Aligned and few barriers to accessing service if deemed medically necessary ≈ : Aligned, yet barriers to accessing services exist ~ : State plan language doesn't cover service or ambiguity remains, multiple barriers exist to accessing service	Targeted Case Management for SMI	HCBS Waiver (Aging & Disabilities Waiver)/ State Plan Personal Care Program	IID/DD HCBS Waiver (Traditional DD Waiver)
Case Management/Care Coordination	√		√
Individual Counseling			
Peer Support Services/ Certified Recovery Coach			
Outreach	~	~	≈
Conducting a screening and assessment of housing preferences/ barriers related to successful tenancy	≈	~	√
Developing an individualized housing support plan based on assessment	≈	≈	√
Assisting with rent subsidy application/certification and housing application processes	≈		√
Assisting with housing search process	~		√
Identifying resources to cover start-up expenses (e.g., security deposits, furnishings, adaptive aides, environmental modifications)	√		√
Ensuring housing unit is safe/ready for move-in			√
Assisting in arranging for and supporting the details of move-in	≈		√
Developing an individualized housing support crisis plan	~		≈
Individualized Service Planning	√	≈	√
Referrals to other services and programs	√		
Providing early identification/intervention for behaviors that may jeopardize housing	√	√	√
Education/training on the role, rights and responsibilities of the tenant and landlord	≈	≈	√
Coaching on developing/maintaining relationships with landlords/property managers	≈	≈	√
Assisting in resolving disputes with landlords and/or neighbors	≈	~	√
Advocacy/linkage with community resources to prevent eviction	√	√	√
Assisting with the housing recertification process	≈	≈	√
Coordinating with tenant to review/update/modify housing support and crisis plan	~	≈	√
Continuing training on being a good tenant and lease compliance	≈	≈	√

¹⁰ Note: The Waiver programs included in this analysis were selected based on the appropriateness of the services and their alignment with the needs of adults in supportive housing. There are other Medicaid Waivers in North Dakota that were not included in this analysis due to the focus on supportive housing.

B. Tenant Profiles: Navigating the Medicaid system for supportive housing services

There are endless combinations of scenarios that play out day to day as clients seek Medicaid-covered services in North Dakota. The client journeys below highlight some of the common successes and barriers clients needing supportive housing services might face if they are eligible to receive Medicaid services under one of the following State Medicaid programs:

1. Targeted Case Management for serious mental illness
2. Home and Community-Based Services Aging and Disabilities Waiver
3. Home and Community-Based Services IID/DD Waiver

The tenant profile section presents realistic depictions of what the client journey for supportive housing services might look like from outreach and referral to stable tenancy and sustained support services.



1. Targeted Case Management

The Targeted Case Management (TCM) benefit is a part of the North Dakota Medicaid State Plan, and is therefore an entitlement benefit available to anyone who meets the eligibility criteria and is able to access the services. Individuals with serious mental illness (SMI) or serious emotional disturbances may be eligible for TCM if they meet the eligibility criteria outlined in the DHS policy manual. The criteria includes an “individual’s age, diagnoses, functional impairment, functional domain, and duration of the mental illness.”¹¹ Many of the services in TCM align with critical supportive housing services if those service are specifically included in a client’s individual treatment plan, deemed medically necessary, and

¹¹ North Dakota DHS Policy Manual. SMI Case Management Eligibility 850-10-35-10.

http://www.nd.gov/dhs/policymanuals/85010/85010.htm#850_10_35_10.htm%3FTocPath%3DSMI%20Recovery%20850-10%7CSMI%20Case%20Management%20Services%20850-10-35%7C____2

support recovery (see chart on page 8 for alignment). This alignment makes TCM one of the clearest ways to theoretically provide Medicaid covered supportive housing services for individuals with serious mental illness or serious emotional disturbance.

However, although many TCM services align with supportive housing services, there are also noteworthy gaps that can impact an individual's ability to remain successfully in their home. The following journey outlines the roadmap to accessing TCM services and the areas where gaps impact access and alignment with supportive housing for a client we'll refer to as Bob.

Bob's Supportive Housing Services Journey: Targeted Case Management

Bob is a 52 year old man who is currently experiencing homelessness and has been living in a shelter for the past 90 days. He is a Medicaid beneficiary living with a serious mental illness. Bob isn't aware of his mental illness, does not have a formal diagnosis of mental illness, and is not aware of targeted case management services. Bob does not have any family or friends that he can count on any longer. His symptoms of anxiety and depression prevent him from initiating interaction with others, and he regularly self-medicates with alcohol to reduce his feelings of fear and loneliness.



OUTREACH

Outreach from a case manager is a crucial component for engaging Bob, building trust with him, and offering the targeted case management services that will help Bob access housing, remain successfully housed, and achieve the stability he wants in his life.



While outreach occasionally occurs by case managers from Regional Human Service Centers (RHSCs) to engage rural community members and educate members on services available at the RHSC, these outreach services are at community centers that Bob does not visit.



In most RHSC areas, outreach does not include "in-reach" to hospitals, shelters, and long-term psychiatric care facilities beyond flyers instructing how to make referrals.



In some cities, case managers go daily to shelters to engage and build rapport, however due to restrictions on engagement by non-licensed clinicians, many case managers are not reimbursed by Medicaid for this critical service. Because of this, outreach often doesn't include the long-term engagement and rapport building needed to target North Dakota's most vulnerable residents, like Bob, who are not engaging with services right now.



Federally-funded Projects for Assistance in Transitions from Homelessness (PATH) case managers can provide coordinated outreach to connect Bob and other unstably housed individuals with RHSC services, yet the level of outreach and community engagement varies based on region and the level of initiative taken by individual PATH case managers.



REFERRAL

In order to begin the process of receiving targeted case management, Bob would need to be referred to his RHSC for a psychiatric assessment, an SMI Determination, a Case Management Eligibility Checklist assessment, and intake.



Bob might receive this referral from a provider agency, like a local hospital or shelter. Bob could also receive a referral from the PATH case manager. A referral from the shelter, hospital or case manager might be done over the phone or using a faxed referral form unique to each agency.



There currently is not a formal process that all RHSCs have with all medical and homeless service providers, so while referrals often occur, each provider may use a different process or referral form. Some providers train staff in referrals while others do not have a formal procedure in place. Some RHSCs send case managers to meet individuals at the hospital Emergency Department, while others may schedule an in-office appointment for an assessment.



If Bob agrees to go to the RHSC, he will have to find transportation to get there. Without a car, transportation to and from the RHSC requires a level of planning, financial resources, and social connectedness that Bob doesn't have. Without support in identifying and paying for transportation, Bob's journey could end here before he receives services.



ASSESSMENT

If Bob receives a referral to his RHSC and finds transportation to get there, his first step is to have an intake assessment.



Intake at first arrival to a RHSC includes a psychiatric assessment using the World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0) and the Daily Living Activities Functional Assessment (DLA 2.0). During this initial intake, Bob will meet with a case manager. He will also need to meet with a Psychiatrist to determine if he has a serious mental illness or serious emotional disorder.



If a Psychiatrist is not available when Bob first arrives to the RHSC, or if the RHSC does not have open access (walk-in) appointments, Bob will need to find a way to return for an appointment another day. Transportation for a Psychiatrist visit may be reimbursable for Bob, if Bob is already enrolled in Medicaid.



Because Bob does not know he has a mental illness and he doesn't have a lot of people he can trust, he may not be inclined or able to navigate finding transportation to go to an office to meet with a Psychiatrist as a precondition of receiving services.



If Bob arrives to a Psychiatrist visit under the influence of drugs or alcohol, the psychiatrist cannot ethically diagnose Bob with a mental illness. While the psychiatrist may determine that Bob has a substance use disorder, a substance use disorder alone does not qualify Bob for TCM under North Dakota's State Plan. Bob's journey would end here, despite his need for services.



If the case manager at the RHSC learns that Bob doesn't already have Medicaid, she will need to assist him in applying for Medicaid, which could require another visit and Bob finding transportation for his way back. Unlike the psychiatrist visit, this transportation is not reimbursable.



If Bob does not have appropriate IDs, his birth certificate, and necessary documentation to apply for Medicaid, this may require a visit to a community health center to meet with a Certified ND Navigator for help applying. Case managers do not ordinarily assist outside of the office setting at community locations such as social security, and they do not assist with providing transportation to and from a non-medical appointment. When they do, this transportation is not a covered service. If Bob's symptoms prevent him from independently accessing transportation, making and keeping an appointment with a Certified ND Navigator, his journey could end here.



Housing stability questions are included in the functional assessment (DLA 2.0) to help determine functional status and case load size. Housing stability could greatly impact Bob’s recovery and is one of his personal life goals. Bob and his case manager add this need to his functional assessment and include it in his individual services plan.



SERVICE PLANNING

Once Bob is enrolled in services, he will need to continue to make and keep appointments to visit the RHSC to receive services.



Transportation to and from the RHSC is not included as a covered service provided for Bob, unless it is for a medical psychiatrist visit. Bob’s journey to recovery ends here if Bob is not able to access reliable, safe, affordable transportation to see his case manager for service planning. It is not likely that Bob will be willing or able to continue to manage visiting the RHSC for ongoing appointments while he is dealing with the daily challenges of living in shelter and his illness.



Some RHSC case managers will meet clients in the community. This varies across the State based on a number of regional and managerial factors at the RHSC level and transportation time is not reimbursable by Medicaid for case managers to conduct these community visits.



If Bob returns to the RHSC, a case manager will work with Bob to create an individual service plan. If Bob and the case manager identify stable housing as an important part of Bob’s mental health recovery and as one of his goals, the case manager can work with Bob to create a service plan that includes housing goals and interventions. This can include assisting Bob as he searches for an apartment and applies for the apartment.



SERVICE PROVISION

DHS has created excellent practice guidelines for case managers in The North Dakota DHS Policy Manual for SMI Recovery, Recovery Practice Guidelines (850-10-25-30)¹². These guidelines encourage case managers to meet clients in the community¹³, to address needs for decent housing, and work closely with the people who play important roles in the client’s life- including landlords. Guidelines are a good step for encouraging a change in practice, yet guidelines fall short as they are not requirements and contribute to the variability seen in how services are provided in Regional Human Service Centers across the State.



Depending on the region in which Bob lives, he may not receive needed services in the community, as his local RHSC may primarily provide services in the office setting. He may not have a case manager that is aware of the DHS guidelines, and because these guidelines are requirements,

¹² North Dakota Department of Human Services Policy Manuals. Program Policy Manuals, Mental Health and Substance Abuse Services. SMI Recovery Policy Manual. [Recovery Practice Guidelines 850-10-25-30](#).

¹³ Outlines that case managers acting in accordance with recovery guidelines will be “willing to offer practical assistance in the community contexts in which their clients live, work, and play. In order to effectively address “individuals’ basic human needs for decent housing, food, work, and ‘connection’ with the community,” practitioners are willing to go where the action is, i.e., they get out of their offices and out into the community. They are prepared to go out to meet people on their own turf and on their own terms, and to “offer assistance which they might consider immediately relevant to their lives.” The policy goes on to say that “the focus of care includes the process of overcoming the social and personal consequences of living with psychiatric and/or substance use disorders”....and having “an intimate knowledge of the communities in which their clients live, the community’s available resources, and the people who are important to them, whether it is a friend, parent, employer, landlord, or grocer.”

community-based services may not be included in a case manager’s job description nor included in case management job performance reviews. As such, Bob might not receive the care he needs if his case manager isn’t expected or able to 1) address his need for housing, 2) work closely with Bob’s landlord, and 3) meet with Bob regularly in the community.

STOP If housing related services are limited to support that is provided in the office setting Bob would not receive assistance in visiting units and signing a lease in the community, which are services that Bob will need to successfully identify a unit, complete the housing application and move in to his new home.

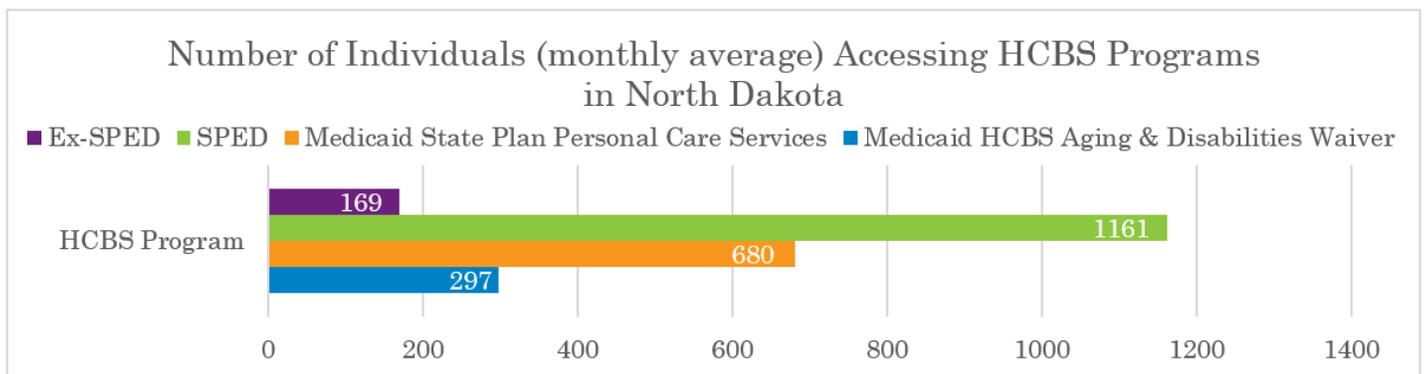
GO Some RHSC’s offer Integrated Dual Diagnosis Treatment groups in the community for individuals who are in recovery from substance abuse. If Bob became aware of his mental illness and substance use issues and wanted to join one of these groups, he would have to find where they were located and then arrange transportation (that is not covered by Medicaid) to these groups meetings, or he might be lucky and find one closer to the shelter where he lives than the RHSC office.

STOP If Bob is unable to navigate this process and is not in touch with the RHSC for six months, he will be discharged from services.

2. HCBS Aging and Disabilities Waiver

The process for an individual to receive home and community based care services varies depending on income eligibility, liquid assets, and an individual’s level of need based on a functional assessment identifying level of impairment and duration of impairment.

In North Dakota, HCBS is a term used to refer to several programs¹⁴ providing care in home and community-based settings, including the Medicaid HCBS Aging and Disabilities Waiver services, the Medicaid State Plan Personal Care Services, and non-Medicaid programs funded by state general funds. These non-Medicaid programs include Service Payments for the Elderly and Disabled (SPED) and Expanded Service Payments for the Elderly and Disabled (Ex-SPED). Similar to Medicaid HCBS services, individuals are eligible for these state funded programs based on age or disability status, as well as their need for services based on an assessment of functional impairment and financial resources including income and liquid assets.



¹⁴ Chart above depicts a snapshot of the number of people served during a single month by HCBS programs in North Dakota. Program census taken during a single month in 2016 and provided by ND DHS staff.

Anne's Supportive Housing Journey: HCBS Aging & Disabilities Waiver

Anne is 79 years old and a beneficiary of both Medicare and Medicaid. Anne lost her home due to a foreclosure and has most recently been renting an apartment. She has been in and out of nursing care facilities for short term stays following a series of falls and hip surgery. During her most recent hospital stay, Anne received an eviction notice from her landlord after not paying rent for three months. Her daughter, who lives out of state, is encouraging Anne to stay at the nursing facility, as Anne now has early signs of dementia and no family nearby. Anne would prefer to return to her previous apartment complex and live with her cat at home. Anne would need both supportive housing tenancy supports to help her remain stably housed and HCBS services for completing activities of daily living. Anne is feeling pressure from her daughter to stay in the nursing home but missing her cat and her home, and she doesn't want to live in an institution. Supporting Anne to receive services at home would be both client-centered and cost-effective.



OUTREACH



Anne may be referred by a staff member at the nursing home following the assessment (Minimum Data Set) which is completed by nursing facilities. Findings during this assessment can trigger a referral for Anne to the Local Contract Agency and a discussion of community services and housing options.



HCBS case managers rarely make nursing home facility visits and do not do so without a referral. If Anne's desire to remain in the community did not come out during the nursing facility assessment, Anne could also self-refer if she was aware of her options. With Anne's limited knowledge of her options to remain in her apartment, Anne's journey might never begin.



REFERRAL



If, through the assessment process, a staff member at the nursing home identifies Anne's desire to return to the community and her need for community based services, he can make a call to the RHSC and refer Anne for HCBS services.



The HCBS Aging and Disabilities Waiver case manager can receive a referral call from the nursing care facility or from the Local Contract Agency referring Anne for services. The HCBS case manager can visit Anne at the nursing home.



While a case manager can initiate a visit to the nursing home facility (nothing bars them from doing so), this is not actually a formalized part of the referral process, job description, or formal assessment.



Without pre-tenancy services to help Anne negotiate with her landlord to keep her unit or find a new one that is safe and affordable on her limited income, Anne will not be fully prepared to return to the community to take the next step in welcoming the HCBS case manager in for a home assessment.



ASSESSMENT



The HCBS Waiver assessment examines the home environment including the physical environment and an individual's technology needs in the home. It also assesses economic assistance needs, including housing assistance through housing vouchers.



Anne's housing needs not only include the physical environment and technology needs supporting her mobility, but Anne would also benefit from assessment questions that identify barriers to successfully remaining housed that include lease obligations and tenant responsibilities such as timely rental payments.



Anne could also benefit from assistance communicating with her landlord in order to prevent future eviction scenarios like the one she just experienced. The current HCBS Waiver assessment does not include housing stability questions beyond the physical environment and economic need.



Anne's symptoms of dementia may impact her ability to make timely payments or communicate repair needs to her landlord, which could result in a loss of her housing.



A copy of the assessment is available to all county staff but is not generally shared with providers. Providers only routinely receive a copy of Anne's service plan. If Anne is aware that she can request that her assessment be shared, she can do so, however this opportunity puts the burden of care coordination on Anne rather than formalizing care coordination roles among the professionals providing the services. Expecting clients like Anne to initiate care coordination means that her needs could be missed, as she may not know what level of care coordination is possible, and she may be not be able to articulate her care coordination needs due to active symptoms of dementia.



SERVICE PLANNING



If Anne is able to return to her home or find a new one, an RHSC case manager will work with her to create a personal care plan¹⁵ that can include many of the tenancy sustaining services common to supportive housing. As noted in chart on page 8, if a case manager is thorough and assesses more than what is included in the formal assessment, Anne's need for assistance with communicating needs to her landlord and support with budgeting and timely rental payments can be included in her plan. This case manager would then determine the number of service hours for which Anne is eligible and Anne would then select a local service provider of her choice.



If Anne has trouble making a decision about which provider agencies she wants for each service, the case manager can help her to select provider agencies and individuals within those agencies.



Anne's case manager has a case load of nearly 100 clients and is overwhelmed keeping on top of all her clients' needs. Her case manager is very attentive during their home visits, but is only able to visit once every three months (the minimum requirement). There is no maximum case load size for HCBS

¹⁵ Anne would not receive a personalized care plan if she were to select Personal Care from the State Plan rather than Home and Community-Based Services through the Medicaid Waiver. Personal care plans are limited to a service plan that outlines the number of eligible service hours per day. The HCBS waiver requires a personalized care plan that includes goals, interventions, and activities that are uniquely selected together with the client and personalized to her/his needs.

case managers, so this varies from RHSC to RHSC, based on staffing and demand. This means that any adjustments needed to the service plan would need to be initiated by Anne (or her provider agency) or wait until the next three month visit from her case manager. Expecting clients to initiate changes to their service plans means that some of the most vulnerable clients' needs will be missed, as symptoms may prevent them from being able to articulate their needs and advocate for themselves.



SERVICE PROVISION



If services are authorized by Anne's case manager and providers are available in her area to provide those needed services, Anne can receive the full range of tenancy sustaining services that align with covered HCBS services.



In order for these HCBS services to allow Anne to remain successfully in her home, care coordination for ongoing assessment and updated personal care plans must include both the case manager authorizing services and the service provider working directly with Anne day to day. Anne can choose to have anyone at the care plan meeting, including her daughter and the provider. The waiver plan requires the provider signature on personal care plans and should also include provider participation, unless Anne refuses.

3. Intellectual and Developmental Disabilities Waiver (Traditional DD Waiver)

The IID/DD Waiver provides home and community based services to individuals with intellectual and developmental disabilities from birth until death. Eligibility for these services is determined by a Developmental Disabilities (DD) case manager at the RHSC. Case managers and providers (both non-profit and for profit) have access to a shared data system where client service plans, assessments and protected health information can be securely accessed by all providers for care coordination.

Matt's Supportive Housing Services Journey: ID/DD Waiver

Matt is 19 years old and has been living with his mom, his primary care giver, for his entire life. Matt has a developmental disability that impacts his ability to live independently without supportive services. This last month Matt's mom suffered a stroke and is now unable to care for Matt in her home. Matt and his mom see this as an opportunity for Matt to move into his own apartment near his Mom's house, if there is a provider in the area that can support Matt in living safely on his own.



OUTREACH



Because Matt was in the school transition program, he had teachers, job coaches and transition staff available to connect him to the DD Waiver and vocational rehabilitation, during the time of his mom's stroke.



If Matt had not been working with the school transition program, and had instead been receiving DD services, a DD Case Manager could update Matt's service plan and connect Matt to a provider of Matt's choice.



If Matt's mom's home wasn't safe for Matt to stay in while she was recovering, a DD provider may need to find Matt temporary housing until an apartment of his own is located. A lack of housing options for crises like this one could mean that Matt is in a hotel receiving DD services until an apartment is found.



REFERRAL



If a staff member on Matt's school transition program team identifies Matt's desire to return to the community, she can make a call to the RHSC and refer Matt for HCBS IID/DD services.



The HCBS IID/DD Waiver case manager will receive the referral call from Matt's teacher and schedule a community visit appointment to meet Matt wherever it is most convenient for Matt for an assessment. IID/DD Waiver case managers are provided with vehicles and able to conduct community visits, as often as needed.



ASSESSMENT



The HCBS IID/DD Waiver support services are based on a risk assessment.



A copy of the assessment is available to both county staff and relevant IID/DD provider agencies through the secure online data portal. County staff and providers have shared access to all assessments and service plans.



When Matt's assessment is posted, service providers in the region that offer services on Matt's service plan can agree to serve Matt. If more than one service provider responds, Matt and his mom will have the opportunity to select the provider agency he wants, based on in person interviews.



If the DD Case Manager determines in his assessment that Matt requires housing-related pre-tenancy or tenancy sustaining support services, the DD Case Manager can include these in the service plan.



SERVICE PLANNING



A provider agency can begin working with Matt upon assessment and Matt's acceptance of the agency. All future assessments and service plans will be created in coordination with Matt, the service provider agency, the DD Case Manager and anyone else that Matt would like to include, such as Matt's mom.



Matt's DD Case Manager will work with Matt, Matt's mom and the provider organization to create a personal care plan that can contain many of the services common to supportive housing to assist Matt in getting into housing and remaining successfully housed.



The service plan that was created collaboratively will then be shared through the electronic health record system that both RHSC staff and service provider agencies have access to.



The DD Case Manager and/or the selected service provider can help Matt find a unit, set up rental payments, and ensure the unit is safe and ready for Matt to move in. All pre-tenancy supportive housing services, except outreach, align with the IID/DD Waiver services and can be provided by the service provider to Matt.



Matt's DD Case Manager can negotiate up to 24 hours of services, based on the Matt's level of need. A non-profit or for profit service provider, or multiple service providers, will be selected by Matt and his DD Case Manager.



From this point forward, Matt will have a day to day relationship primarily with the service provider, yet Matt’s DD Case Manager will conduct annual assessments and renew the service plan with Matt annually (at a minimum).



Within the IID/DD service needs assessment and service planning process, there is no formal requirement that service providers create a housing crisis prevention plan or an eviction prevention plan. Program coordinators do, however, look at all aspects of housing and safety, which can informally include eviction prevention activities or housing crisis prevention. Because it is often done in an informal way, on a case by case basis, responding to housing crises tend to be more reactive rather than preventive.



SERVICE PROVISION



If services are authorized by Matt’s DD Case Manager, in his service plan, and providers are available in his area to provide those needed services, Matt can receive the full range of tenancy sustaining services that align with covered HCBS IID/DD Waiver services.



If Matt developed a substance use disorder, or was viewed by providers as “difficult to serve”, he may not have many, if any, providers offering their services. Supportive housing is highly successful for meeting the needs of highly vulnerable individuals who have multiple, complex, and chronic health needs, including substance use disorders. If North Dakota providers decide they cannot or do not want to serve someone like Matt, he could end up in an institutional setting.



RE-ASSESSMENT & SERVICE PLAN UPDATES



As Matt learns new skills and faces different challenges, Matt’s supportive housing services needs will evolve. The DD Case Manager completes an updated needs assessment every year and include risk assessments, safety assessments, and vocational assessments. This updated assessment is used to inform a new services plan annually- including client, family members, anyone the client wants to include.



Service plans can be updated at any point, and aren't limited to the required annual assessment. Service planning meetings can be requested by the client, the provider agency, or the DD Case Manager. It would not be uncommon for Matt, his mom, and all providers interfacing with Matt to meet monthly, at the provider or client’s request.

IV. RECOMMENDATIONS

A. Create a Supportive Housing Services Benefit in North Dakota’s State Plan.

Supportive Housing Services should be explicitly included in the North Dakota State Plan to align with CMS guidelines of pre-tenancy and tenancy-sustaining services included in the CMS Informational Bulletin released on June 26, 2015.

In order to include these services in the state plan, the state will need to seek a state plan amendment or a Waiver from CMS to add a benefit to cover these services. Multiple waivers offer the opportunity to include these services in the state’s benefit structure. Following is a brief comparison of three Medicaid

authorities that best align with including supportive housing services. CSH is available for consultation to further explore these options with the State.

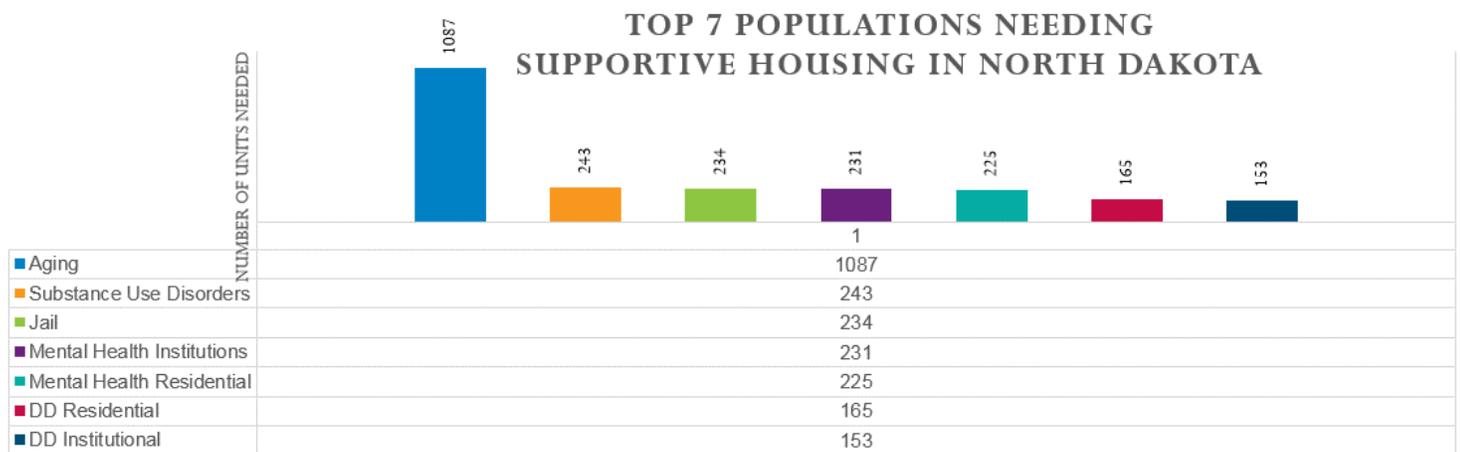
State Plan Options Best Suited to Creating a Supportive Housing Services Benefit			
Plan Option for adding pre-tenancy and tenancy-sustaining services	HCBS 1915i State Plan Amendment	HCBS 1915c Waiver	1115 Waiver
Brief Description	Home and Community-Based Services	Home and Community-Based Services	Flexible waiver for demonstration programs to pilot innovative care delivery models that differ from federal rules
Eligible/Covered Populations	Beneficiaries with disabilities requiring HCBS who meet approved “needs-based criteria” but who are <u>not</u> necessarily at risk of institutionalization	Beneficiaries leaving or at risk of institutionalization	Any Medicaid-eligible beneficiary
Considerations	Must offer coverage statewide; cannot restrict targeting by geography. No federal cost neutrality requirement	Narrow eligibility parameters. Subject to cost-neutrality.	High standards for evaluation methods that will demonstrate better outcomes and lower costs

B. Cover and expand supportive housing and targeted case management services to include individuals with substance use disorders.

Supportive housing is recognized as an appropriate platform for providing addiction treatment services. A Supportive Housing Services benefit (explained in Recommendation A) should target not only individuals with serious mental illness and individuals exiting institutions, but also individuals who are chronically homeless with substance use disorders. The continuum of treatment options for individuals with substance use disorders must be expanded to include those that are homeless and actively using. The North Dakota Department of Human Services continues to adopt more evidence-based practices for substance use disorder treatment including motivational interviewing, Integrated Dual Disorder Treatment, and in some regions, substance abuse treatment groups held outside of the RHSC, in the community. CSH estimates that individuals with substance use disorders represent the second largest group of people in need of supportive housing in North Dakota. This is outlined in the following chart and can be referenced at csh.org/data for detailed information on data sources for this state-wide estimate.

Supportive housing is an evidence-based practice recognized by the Substance Abuse and Mental Health Services Administration (SAMHSA) because supportive housing builds a foundation for recovery, improves the integration of behavioral and physical health care, and promotes the collaboration between treatment providers and homeless system providers. This integration can be accomplished through an 1115 waiver that covers supportive housing services for adults 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).

Figure 1: Supportive Housing Need in North Dakota- Top 7 Populations¹⁶



C. Redirect cost savings back to behavioral health 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 contributed to reductions in emergency department visits, overnight hospital stays, and days spent in nursing homes and long-term care facilities. Once realized, federal cost savings should be redirected back into supportive housing services. State and managed care cost savings can be redirected back into supportive housing services and supportive housing rental subsidies. As Medicaid increasingly covers supportive housing services, supportive housing providers can then direct other funding sources to cover more rental subsidies and other housing expenses.

D. Weave medically-necessary housing services into Regional Human Service Center operations.

Throughout the review of covered services, it became apparent that many targeted case management services and home and community-based services do allow for pre-tenancy and tenancy sustaining services, and in some cases provide best practice guidelines for person-centered care that addresses housing needs. Unfortunately, guidelines are not enough to produce streamlined system change across all Regional Human Service Centers, services aren't often community-based, and caseloads are too high to offer the level of support highly vulnerable people need. This system wide movement toward best practices in the State could be accelerated by updating the following aspects of service delivery to address housing, transportation, and care coordination needs:

Assessment questions

Housing needs and preference questions should be included in all Medicaid services assessments, including targeted case management for SMI, all HCBS programs, substance use disorder treatment programs, and long-term care and nursing care facilities.

¹⁶ References and citations for supportive housing need estimates can be found at http://www.csh.org/data_reports

Individualized service plans for all HCBS recipients to include housing crisis support planning

The aging population in North Dakota has been identified as needing more supportive housing units than any other vulnerable population. North Dakota's home and community-based service plans vary depending on whether or not the individual is eligible for Medicaid. All HCBS service plans should be individualized and include a plan for addressing housing crises and promoting housing stability, regardless of the payer source (Medicaid State Plan, Medicaid HCBS Waiver, SPED, or Ex-SPED).

Case manager job descriptions and case loads

Whereas case manager activities surrounding community visits and addressing housing needs are currently outlined as guidelines, these activities would be highly effective as required activities as elements of a case manager's job description and performance reviews. Case load ratios should be set with a maximum number of clients to case manager ratio that accommodates community and in-home visits. This is already done with targeted case management for SMI, but is not yet in place for all HCBS services.

Additionally, current state plan requirements limit certain non-clinical services to licensed clinical staff. Services that are key to targeted case management for the most vulnerable individuals, like ongoing outreach, client engagement, and 24-hour crisis response, should be expanded to permit non-licensed staff to complete (and be reimbursed for) such activities, under the supervision of licensed clinical staff.

Outreach and in-reach formalized with shelters, long-term care facilities, nursing homes, and hospitals

Outreach, in-reach, and referral processes should be formalized with all referring entities through shared referral forms, common assessment questions, combined staff training, and formal data sharing partnership agreements for sharing protected client information for the purpose of coordinating care.

Staff training in supportive housing using a housing-first lens

Supportive housing is increasingly promoted as an evidence-based health intervention through managed care and CMS. In adopting a housing first model of supportive housing, North Dakota will see increased success in meeting its goal of promoting evidence-based cost-effective programs, while delivering the right care at the right time to the people who need it most. In order to promote this evidence-based practice, RHSC staff, PATH staff, and providers across the State would benefit greatly from supportive housing training.

V. CONCLUSION

CSH applauds the State of North Dakota's Department of Human Services for creating a Medicaid Supportive Housing Services Crosswalk. The state has clear building blocks for better serving its most vulnerable residents who currently fall through the cracks. The recommendations in this report are in line with the goals of the DHS and stakeholders in the state who know supportive housing is the solution for a subset of Medicaid beneficiaries. This report offers a thorough analysis that confirms the need for a supportive housing services benefit for a subset of Medicaid beneficiaries. The Grand Forks Housing Authority's efforts to inform and educate stakeholders state-wide about the need for supportive housing services and the potential for Medicaid to pay for those services is creating momentum for policy changes that would be beneficial to the State, providers of Medicaid services, and North Dakota residents who are most in need.