A Quick Guide to Improving Medicaid Coverage for Supportive Housing Services

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Introduction

The U.S. Department of Health and Human Services (HHS) Office of the Assistant Secretary for Planning and Evaluation (ASPE) has published two reports on using Medicaid in supportive housing: Primer on Using Medicaid for People Experiencing Chronic Homelessness and Tenants in Permanent Supportive Housing[1], and Medicaid and Permanent Supportive Housing for Chronically Homeless Individuals: Emerging Practices from the Field[2]. This Quick Guide is designed to provide a brief overview of information in these reports and other resources to help states, community health centers, behavioral health clinics, and supportive housing providers use Medicaid more strategically to serve people who are highly vulnerable and who need supportive housing.

New Opportunities for Supportive Housing

Supportive housing[3] combines affordable housing with case management and other supportive services to help people who face the most complex challenges to end their homelessness, leave institutional care, or otherwise maintain stable housing and achieve improved health and social outcomes. Attachment A provides an overview of the services delivered in supportive housing.

Supportive housing is recognized as a key solution to homelessness, particularly for people experiencing chronic homelessness. Numerous studies have also documented supportive housing's cost-effectiveness and potential for reducing people's use of crisis health care services when they successfully live in their communities. Despite the broad agreement and evidence regarding supportive housing, communities continue to face challenges in their ability to bring supportive housing to scale. This is because the creation of supportive housing requires achieving a coordination of both housing resources and funding for supportive services. Funding for supportive services has been particularly challenging to acquire as there are few funding streams that are specifically designed to cover services in supportive housing. Funding services in supportive housing has been like putting together a puzzle and often one with many pieces missing.

As the documents published by HHS indicate, Medicaid offers communities a better way to solve this puzzle. Medicaid can cover and pay for many of the services in supportive housing, including case management, services coordination, and rehabilitative services. And with the state option to expand Medicaid eligibility under the Affordable Care Act, more people experiencing homelessness will be eligible for Medicaid, making Medicaid a viable option to cover services for many more people. However, as a state-administered program, states have significant discretion over what services to cover under Medicaid. In other words, while Medicaid *can* cover the services for people in supportive housing, the degree to which it actually *does* will depend upon the choices and decisions that states make. It is therefore critical that state Medicaid agencies be fully educated about the benefits and outcomes of supportive housing and the options they have to cover services in supportive housing.

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

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

[3] Many federal programs and agencies formally refer to supportive housing as "permanent supportive housing." The definition is the same and the two phrases are used interchangeably.

How Can Supportive Housing Services be Covered Under Medicaid?

The Centers for Medicare & Medicaid (CMS) have agreements with each state that describe how the state and federal governments will administer and pay for Medicaid benefits for eligible beneficiaries. These agreements are called Medicaid state plans. Medicaid operates similar to any private insurance program. In order for state Medicaid agencies to reimburse providers for services delivered, those services must be included as a benefit within the Medicaid state plan. Federal law, Title XIX of the Social Security Act (the Act), provides broad federal guidelines for states to operate their Medicaid programs. Under the federal Medicaid program, states are required to cover certain mandatory benefits. States can also elect to provide an array of optional benefits through their Medicaid state plans. All state plan benefits are described in section 1905(a) of the Act, but section 1905(a) benefits are only one authority states may use to provide services to Medicaid eligible individuals. There are several authorities and opportunities listed below that offer ways for states to use Medicaid to provide services that are important to supportive housing. Some offer avenues to specifically cover tenancy supports—the critical services that ensure people can access and remain in housing. (Attachment B provides an at-a-glance comparison of these opportunities.)

1115 Waivers

1115 Waivers offer broad flexibility for states to explore innovations and demonstration projects in the delivery of care and to pay for services not typically covered by Medicaid. The federal government allows these services to be covered under an 1115 Waiver as a way of testing their impact on health outcomes and costs.

- States may target specific populations for receipt of 1115 Waiver services.
- The high level of flexibility available through 1115 Waivers could allow Medicaid to pay for services in supportive housing in a variety of ways.
- Because states have a wide range of possibilities to consider in applying for an 1115 Waiver, the level of stakeholder engagement and decision making required is high.
- States must demonstrate that changes made are cost-neutral to the federal government.

1915 Home and Community Based Services Waivers and State Plan Amendments

Home and Community Based Services (HCBS) allow Medicaid beneficiaries with disabilities to receive services in their own home or community as an alternative to costly institutional care such as nursing homes, intermediate care facilities, and hospitals. States can cover HCBS through different types of State Plan Amendments (SPA) and waivers.

- A 1915c HCBS Waiver allows states to create specific packages of services for people who are institutionalized or at risk of institutionalization. States may limit implementation to a number of eligible beneficiaries under the1915c Waiver.
- The 1915i HCBS SPA allows states to create specific packages of services for people who meet disability criteria as defined by the state. States may target the services to specific geographic areas such as cities and counties under the1915i Waiver.
- The package of services established under HCBS waivers or state plan amendments can include some of the tenancy support services in supportive housing that are not typically Medicaid-reimbursable, such as pre-tenancy outreach and engagement and assistance with ongoing leasing and subsidy requirements.
- CMS's requirements for HCBS settings are well-aligned with the best practices of supportive housing, including but not limited to tenancy protections, choice, and privacy.

1915b Waivers for Managed Care

A 1915b Waiver allows states to use managed care to administer and deliver services for the Medicaid program. This waiver is often coupled with an 1115 waiver, a HCBS waiver or a state plan amendment to allow services established through these mechanisms to be delivered using a managed care organization.

  - States use managed care entities to assist with controlling Medicaid costs and improving care coordination as patients navigate the health care system.

- Several states have Medicaid programs completely administered via managed care entities. Other states carve out specific Medicaid eligible populations for managed care options. States then issue a request for proposals which managed care entities answer and if awarded then contract with the state. These contracts establish outcome measures and the financing structure the state will use to compensate the managed care entity. The managed care entity then establishes partnerships with local community agencies that will be reimbursed by the managed care entity to deliver services. Some managed care entities deliver various services directly.

Medicaid Health Homes

Health Homes are not housing; rather they are comprehensive systems of care coordination for Medicaid beneficiaries with chronic conditions.

- This optional Medicaid state plan amendment was created within the Affordable Care Act in 2010 through Section 2703.
- Health Home care coordination must be targeted to populations with multiple chronic conditions and/or mental illness.
- Service payments may be tiered or risk-adjusted to provide higher payments for participants who have more chronic health conditions, more severe conditions, or greater complexity.
- States implementing Health Home care coordination benefits can receive a 90 percent enhanced federal match for the first eight quarters in which the program is effective.
- States applying for the Health Home demonstration can name the benefits and types of care coordination they will provide, including coordination with housing.

Optional Medicaid Services

Rehabilitative Services

Medicaid's rehabilitative services benefit or "rehab option" focuses on restoring, improving, and/or preserving a person's individual and community functioning in ways that are consistent with goals related to recovery, resiliency, independent living and enhanced self-sufficiency. All 50 states and the District of Columbia cover behavioral health services to some extent under the rehabilitation benefit.

- Under the rehabilitation benefit, all individuals eligible under the state plan are entitled to receive services covered in their state. States have traditionally used the rehab benefit to treat serious mental illness and developmental disabilities, but some states use the option to treat a broad array of conditions.
- The rehab option does not define the specific services that states must provide so it is important to engage stakeholders in determining which services should be covered and discuss these proposed services with CMS prior to submitting a formal proposal. Examples of services states might choose to cover include assessment, plan development, behavioral therapies or counseling, and specific service interventions such as social and leisure skills, personal hygiene, or skills needed to negotiate with a landlord, use public transportation, and access other resources in the community. Assisting a client with completing applications for housing or rental subsidies might be covered if a provider can document that impairments related to a mental illness create a barrier to doing so or that doing so creates anxiety or other symptoms that could make it difficult to be successful.
- States can also use the rehabilitation benefit to provide services included in a beneficiary's plan for care created by multidisciplinary health care and supportive housing teams. One example is assertive community treatment.
- Under the rehab option, services must be recommended by licensed practitioners, paraprofessionals, and/or peer support specialists.
- Service delivery must be documented in a way that clearly demonstrates a link between interventions and objectives. Services must address the functioning issues or barriers identified in the client plan.

- The rehabilitation benefit can cover services delivered in a range of settings including the beneficiary's own home or community.
- Services provided under the rehab option are included through a CMS-approved Medicaid state plan.

Targeted Case Management

Targeted Case Management (TCM) services assist individuals in accessing medical, social, educational and other services. TCM may include a comprehensive assessment, periodic reassessment, service plans, referrals and linkages, and monitoring.

- States may target the TCM benefit to specific groups of beneficiaries based on their disease or medical conditions, including, but not limited to people with HIV/AIDS, tuberculosis, chronic physical or mental illness, or developmental disabilities.
- TCM care plans can include referrals to appropriate housing, communicating with a landlord on behalf of a client, helping clients understand the requirements of programs or services in which they are participating (including housing or other community resources), and monitoring a client's progress.
- States may target the benefit to specific geographic areas such as cities and counties.
- Services can be delivered in a range of settings including the beneficiary's own home or community.
- TCM services are included in a CMS-approved Medicaid state plan.

Medicaid Benefits Delivered in Primary Care Clinics

Under the federal Medicaid program, benefits provided in community health centers, including homeless, rural, migrant, and public housing clinics, can receive Medicaid reimbursements for the delivery of primary care and preventive services to people with low incomes in underserved communities. Health centers and other primary care clinics that receive Medicaid reimbursements can partner with supportive housing providers to improve access to services and supports for residents. This can also free up needed housing resources that have been used to fill gaps in services funds.

Primary care health facilities must meet all the same federal requirements in order to receive Medicaid reimbursement for support services as other providers, and the services must be included in an approved Medicaid state plan. As with other facilities, health centers that choose to partner with housing providers and deliver supportive housing services must secure grants and other resources to support non-Medicaid reimbursed services. Health Centers can play a key role in working with the states and local policymakers to improve Medicaid reimbursement for supportive housing services. The following are key considerations for primary care providers to consider when targeting services to supportive housing residents. Medicaid & PSH: A Quick Guide for Health Centers provides additional guidance to health centers about Medicaid and supportive housing

- Primary care clinics that already bill Medicaid are uniquely positioned to partner with housing agencies that have residents with high needs but do not have the infrastructure necessary to bill Medicaid.
- Cost and patient information can be used to demonstrate supportive housing's effectiveness in controlling costs, improving care, and maintaining access to primary care.
- Health Care for the Homeless clinics (HCH) may consider residents of supportive housing as "homeless" for purposes of continued eligibility for HCH services and to avoid exceeding a 25 percent cap on serving housed patients[4].
- Health centers can provide on-site services through home visits or satellite clinics located in or near supportive housing for people who are homeless.
- Health centers can partner with behavioral health and supportive housing providers to create multi-disciplinary teams to provide integrated care for people experiencing homelessness and those living in supportive housing.

[4] For more information on this provision, see HRSA Policy Information Notice 2009-05.

Five Steps to Increasing Medicaid Coverage of Supportive Housing Services

States and providers can take the following steps to more strategically use Medicaid to pay for supportive housing services.

1. Conduct a crosswalk of supportive housing services and those covered by Medicaid.

Because people who need supportive housing are often eligible for Medicaid, it can seem as though Medicaid already covers all of the services they need. But more often than not, the specific tenancy supports that help people access and remain in housing are not expressly covered in most state plans. As well, although most state plans cover case management, people who need supportive housing often need far more intensive levels of case management than that which is paid for by most state Medicaid programs. Conducting a crosswalk of the specific services provided in supportive housing with a state's Medicaid program will identify the gaps that prevent paying for tenancy supports in supportive housing and the opportunities for covering these services more strategically for Medicaid beneficiaries with the greatest needs.

2. Make the business case for supportive housing.

While many people with high needs are eligible for Medicaid, without stable housing the health care system is often unable to engage them in services in a cost-effective way. Medicaid ends up paying a disproportionate amount for those who are high utilizers of emergency health care services. If Medicaid paid for the pre-tenancy and tenancy supports in supportive housing, states could achieve cost savings and restore dignity for many people with disabilities and housing instability. Cross-referencing health care cost data and housing status allows states to determine the cost-savings that can be achieved with supportive housing and make the business case for change.

3. Create a Medicaid supportive housing services benefit.

Using the Medicaid mechanisms described above, states can create a Medicaid benefit that specifically covers pre-tenancy supports, tenancy supports, and moving supports for people who are highly vulnerable. In Creating a Medicaid Supportive Housing Services Benefit: A Framework for Washington and Other States CSH lays out the five factors that decision makers must address to create a Medicaid supportive housing services benefit: benefit eligibility, the package of services to be delivered, Medicaid state plan changes, financing and reinvestment strategies, and the roles of managed care and supportive housing service providers in operationalizing the benefit.

4. Measure success and reinvest savings.

The alignment of Medicaid and supportive housing is a new prospect for most states. Early-adopters of supportive housing and Medicaid integration should measure their success to pave the way for others. States that are successful in using Medicaid more intentionally to address the needs of people who need supportive housing should take their efforts to scale by reinvesting cost savings into services to create new units of supportive housing.

5. Educate. Engage. Partner.

Health care and supportive housing professionals are beginning to learn about each other's fields. It is important that both sectors educate each other about the people they serve and how they deliver services to create a common understanding from which to build new partnerships. Policy makers and decision-makers, particularly Medicaid Directors, need to understand that supportive housing is a solution to the problems of chronic homelessness and unnecessary institutionalization and that they have the power to use Medicaid to significantly enhance their state's ability to create supportive housing.

Conclusion

As communities look for resources to expand supportive housing availability, it is important to increase the role of sustainable programs and resources, like Medicaid. Supportive housing providers, community health centers, and other services providers should engage their state Medicaid programs and advocate for policy change to specifically cover tenancy support services in supportive housing.

ATTACHMENT A
SUPPORTIVE HOUSING SERVICES

Housing-Based Services and Supports for Supportive Housing Tenants

- **Assessment**
  - Services intake
  - Assessment-identifying client need
  - Gathering documents for eligibility determination
  - Arranging for further testing and evaluation
  - Conducting reassessments
  - Documenting assessment activities
- **Service Plan Development**
  - Service Plan Development with client
  - Writing service plan
  - Determining who should provide services
  - Obtaining signatures
  - Update and review service plan
  - Documenting service plan development
- **Referral, Monitoring, Follow-up**
  - Referrals to other ancillary services
  - Referral and related activities
  - Assist in connecting to services
  - Coordination of services identified in service plan
  - Monitoring and evaluation
  - Documenting referral, monitoring and follow-up
  - Personal advocacy
- **Medication management/monitoring**
  - Harm Reduction strategies
  - Substance abuse counseling
  - Peer counseling, mentoring
  - Education about mental illness
  - Psychotropic medication education
  - Recovery readiness
  - Relapse prevention
- **Routine medical supports, medication management, vision, dental, HIV/AIDS services**
  - Medication set-up
  - Medication coordination
  - HIV/AIDS/STD education
  - End of life planning
- **Entitlement assistance/benefits counseling**
  - Entitlement and benefits counseling
  - Application for income and food assistance
  - Application for health benefits, including Medical Assistance and specific programs funded through Medical Assistance
  - Referral to legal advocacy and assistance with appeals
  - Budgeting and financial education
- **Transportation**
  - Transportation - non-medical
  - Care manager accompaniment on appointments
- **New tenant orientation/move-in assistance**
  - Finding housing
  - Applying for housing
  - Landlord advocacy
  - Securing household supplies, furniture
  - Tenancy supports
  - Eviction prevention
- **Outreach and in-reach services**
  - Identifying and engaging individuals
  - Connecting individuals with mainstream services
- **Independent living skills training**
  - Nutrition education
  - Cooking/meal prep
  - Personal hygiene and self-care
  - Housekeeping
  - Apartment safety
  - Using public transportation
- **Job Skills training/education**
  - School connections
  - Access to Social Support
  - Truancy intervention
  - Access to academic support
  - Opportunities/access to GED, post-secondary training
  - Supported employment
  - Childcare (connect people to resources)
- **Domestic Violence intervention**
  - Domestic Abuse Services
  - Crisis planning, intervention
  - Child Protection assessment, follow-up
  - Referral to Legal Advocacy
  - Training in personal and household safety
  - Crisis intervention-clinic based or mobile crisis
- **Support groups Self-determination/Life satisfaction**
  - Grief counseling
  - Development of recovery plans
  - Group therapy
  - Recreation
  - Social Support
  - Community involvement/integration
  - Parenting supports and mentoring
  - Peer monitoring/support
  - Conflict resolution/mediation training
- **Respite Care**
- **Individual counseling**
- **Discharge planning**
- **Reengagement**

Attachment B
A Quick Comparison of Medicaid Authorities for Supportive Housing

	1115 Waiver	1915c HCBS Waiver	1915i HCBS State Plan Option	Health Homes State Plan Option	Medicaid Rehabilitative Services	Targeted Case Management
What is it?	Flexible waiver for demonstration programs that enable States to pilot innovative care delivery models and coverage expansion that differ from federal rules	Medicaid waiver to provide Home and Community-Based Services to populations leaving or at-risk of institutionalization	State plan option to extend Home and Community Based Services to people with disabilities but who are not necessarily at-risk of institutionalization and without cost neutrality requirement	CMS program enabling states to create highly integrated, coordinated, and flexible health/social services networks for people w/chronic conditions; enhanced federal match for 1st 8 quarters	Authority used to cover range of restorative and rehabilitative services	Authority to make case management available to specific populations, including in specific geographic locations to better access and coordinate medical, social, and other care
Eligible/ Covered Populations	Anyone who is also Medicaid eligible. Can also be used to expand Medicaid coverage beyond federal eligibility (e.g. to low-income singles pre-2014)	Beneficiaries leaving or at-risk of institutionalization including seniors, people with SMI, development disabled, PLWAs, or people with TBI	Beneficiaries with disabilities requiring HCBS who meet approved "needs-based criteria"	Beneficiaries with serious mental illness or two or more other chronic conditions	People who are Medicaid eligible under the state plan	States can define and limit coverage to certain beneficiaries, can include PWAs, seniors, children in foster care, people with disabilities inc. substance use
Potential Coverage of SH Services	High (gives States highest degree of flexibility)	Medium (due to cost neutrality requirement)	High (due to no cost neutrality standard)	High (highly tailored services including intensive care management)	Medium to low	Medium to low
Considerations	States must meet high standards for research methods that will demonstrate better outcomes, lower costs. This waiver is subject to federal cost-neutrality	Limited to people leaving or at-risk of entering institutions.	States adopting 1915i must extend coverage statewide; cannot restrict targeting by geography	A hybrid between a payment system and a care model, Health Homes is very new with only a few states adopted	Services tend to be more treatment or rehabilitative as opposed to care management focused	Services focus on accessing (rather than delivering) medical, social, educational and other services.