NEW HAMPSHIRE | 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 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.

Acknowledgements

CSH would like to acknowledge and thank the New Hampshire Housing Finance Authority for their funding and support for this report. CSH would also like to acknowledge the numerous New Hampshire Department of Health and Human Services staff members, including Medicaid Director Deb Fournier, Director of Human Services Maureen Ryan, and Diane Peterson, Administrator within the Medicaid Policy Unit, who provided guidance and clarification on the New Hampshire Medicaid State Plan and its Waivers throughout the Crosswalk review process.

INTRODUCTION

In partnership with Families in Transition and the New Hampshire Department of Health and Human Services, CSH conducted a Medicaid Supportive Housing Services Crosswalk.

The Medicaid Supportive Housing Services Crosswalk examines the extent to which New Hampshire'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 wrap-around care coordination services.

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 reimbursable supportive housing services.
- Part Three – Overview of key areas of alignment and gaps in the Crosswalk of services currently covered by Medicaid, together with interview results from local supportive housing provider agencies about Medicaid reimbursement for the services they deliver.
- Part Four – CSH's recommendations for the steps New Hampshire 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.

TABLE OF CONTENTS

I. Background and Definitions

In New Hampshire, 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 and 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 to a disproportionate percent of New Hampshire's expenditures.

A. Supportive Housing

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, 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 provides specialized, housing-based tenant support services with low client-to-staff ratios (generally one-to-fifteen and not more than one-to-twenty-five).

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 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 more supportive housing. 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 rehabilitation[2] option, the service must meet the purposes of "reducing disability and restoring function.[3] "

D. Medicaid Waivers

States can also 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, 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.

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

---

[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.

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. New Hampshire Medicaid and the Medicaid State Plan

Beginning on August 15, 2014, low-income adults (with income at or below 138% of the federal poverty level) were granted access to health insurance through Medicaid expansion. Medicaid expansion has had a significant impact on New Hampshire residents, as it allows an estimated 64,000 low income adults, many of whom were previously uninsured, to receive covered preventive and primary health care services, among other services.[4] Of these estimated 64,000 newly eligible low-income adults, many are experiencing homelessness and/or living with substance use disorders, chronic health conditions, and undiagnosed mental illness. Now newly eligible for Medicaid services, many of these homeless or unstably housed individuals might also be eligible for supportive housing services.

This Crosswalk report includes a review of New Hampshire's Medicaid State Plan, its State Plan Amendments (SPAs), as well as several Waivers (1915c Choices for Independence and 1115 Transformation Waiver) in order to include highly vulnerable individuals who are living with intellectual and developmental disabilities and individuals who are living at or below 138% of the federal poverty level, newly eligible for Medicaid, and have substance use disorders and/or multiple chronic physical and behavioral health conditions.

A. Managed Care in New Hampshire

New Hampshire DHHS has contracted with two managed care organizations, New Hampshire Healthy Families and Well Sense. The Department has set up a payment contract with both MCOs to provide direct services and to contract with Community Mental Health Centers, Federally Qualified Health Centers, and individual providers to offer Medicaid services to New Hampshire residents. Both MCOs offer the required Medicaid services as well as some optional services, such as case management services and dental services. Beginning in July 2016, individuals in New Hampshire with standard Medicaid (pre-expansion population only) have access to substance use disorder treatment services through managed care.

It is important to note that at the current time, the State has certified one CMHC per region to provide mental health services to all Medicaid members in the designated region. No other agency can become a community mental health center, as this process is closed and limited to one CMHC per region. While New Hampshire Healthy Families and Well Sense are only contracting with one CMHC per region, these MCOs are not limited in the number of Federally Qualified Health Centers and substance use disorder treatment providers with whom they can contract. As such, there is a greater diversity in the number and size of provider agencies who are federally qualified health centers (FQHCs) and substance use disorder (SUD) treatment providers contracting with New Hampshire Healthy Families and Well Sense.

[4] New Hampshire Medicaid. https://www.healthinsurance.org/new-hampshire-medicaid/

B. Fee for Service Reimbursement in New Hampshire

In addition to managed care, which often reimburses through a case rate (i.e.: a set dollar amount per enrolled client per day/month), New Hampshire also operates a fee for service reimbursement system for certain mental health services provided through independent mental health individual providers such as independent Licensed Clinical Social Workers or psychiatrists. These services are reimbursed through state funding that is separate from managed care contracts and paid to providers directly by the state after a service has been provided. A one-hour clinical counseling session with a licensed therapist is one example of a fee for service payment in New Hampshire.

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. Currently, substance use disorder treatment providers contracting with managed care are reimbursed through a fee for service system.

C. New Hampshire's Medicaid Waiver Authorities

There is one 1915(c) waiver in New Hampshire that most directly serves people who need supportive housing. This waiver is a Home and Community Based Services (HCBS) waiver[5] that allows individuals to remain in their own home and community and avoid unnecessary institutionalization in long-term care facilities. Additionally, New Hampshire has implemented two 1115 Research and Demonstration Waivers that have potential to impact supportive housing service providers and recipients.

1. 1915 (c) HCBS Choices for Independence Waiver[6]

The Choices for Independence Waiver is a program of care provision offered by the Bureau of Elderly and Adult Services, within the New Hampshire Department of Health and Human Service. The Waiver program provides home and community based care services as an alternative to nursing home care to adults over age 60 and adults ages 18-60 living with a disability or chronic illness qualifying for the level of care provided in a nursing home. Supportive housing services are identified among the services available to eligible individuals who wish to reside in or return to their home or community through the Choices for Independence Waiver.

2. 1115 Premium Assistance Demonstration Waiver

Following Medicaid expansion, New Hampshire applied for and was approved for a demonstration waiver enacting a Premium Assistance Program that would mandatorily enroll new Medicaid beneficiaries into

---

[5] 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

[6] From the Choices for Independence (CFI) –Home & Community-Based Care Provider Manual, Volume II, March, 2014. "Providers of Supportive Housing Services must be Home Health Care providers licensed in accordance with RSA 151:2 and He-P 809. This service is provided to members who live in federally subsidized individual apartments." It goes on to outline, "The following supportive housing services are included in the per diem payment: Personal care services, as described in He-E 801.22; Assistance with the following activities; 1.Making telephone calls; and 2. Obtaining and keeping appointments; Home health aide services; Homemaker services, as described in He-E 801; Personal emergency services, and Medication reminders and other supportive activities as specified in the comprehensive care plan or which promote and support health and wellness, dignity and autonomy within a community setting."
https://nhmmis.nh.gov/portals/wps/wcm/connect/80193f8043507aaabc5bfdcb77b9ecd5/NH+Medicaid+Final+CFI++Provider+Manual+03-04-14_final.pdf?MOD=AJPERES

qualified marketplace health insurance plans, with Medicaid paying the premiums. This approval was granted by CMS through the "New Hampshire Health Protection Program (NHHPP) Premium Assistance Demonstration" 1115 Waiver. The one-year Demonstration Waiver with its Premium Assistance Program was extended beyond one year through a legislative vote, allowing low-income adults to remain covered through qualified health plans with their premiums paid by Medicaid until December 31, 2018.

3. Building Capacity for Transformation 1115 Waiver

New Hampshire Building Capacity for Transformation 1115 Medicaid Waiver is a demonstration waiver that provides Delivery System Reform Incentive Payment (DSRIP) Project funding to Integrated Delivery Networks of providers who have applied to DHHS with project proposals and received approval for proposed integrated delivery systems of care that address improved care transitions, capacity building and integration of care delivery. Community support providers, including supportive housing and transitional housing providers, have been included as potential IDN provider members that can be included in project funding targeting integrated care and improved health outcomes. The Transformation Waiver highlights the need for data sharing and data system capacity building, as well as providing a focus on high need populations including individuals with substance use disorders and those with complex behavioral and physical health conditions. Supportive housing providers have an opportunity within this Transformation Waiver to begin coordinating with healthcare providers and systems to create demonstration projects that include supportive housing providers and services to realize improved health outcomes, cost savings and system-wide data sharing that integrates housing and health system data for improved care delivery.

III. SUPPORTIVE HOUSING SERVICES CROSSWALK FINDINGS

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 State Plan and the perceptions of providers who deliver supportive housing services. Section A of the Crosswalk details our analysis of alignment between the Plan itself and the services in supportive housing. Section B describes the degree to which supportive housing services are being covered in practice.

A. State Plan Alignment

This section includes an overview of covered supportive housing services outlined in the New Hampshire Medicaid State Plan, State Plan Amendments and relevant waivers. The Medicaid Crosswalk included an analysis of services provided by Community Mental Health Centers (CMHC), Federally Qualified Health Centers (FQHC), Substance Use Disorder Treatment Providers (SUD) and Choice for Independence Waiver Providers (CFI) that align with supportive housing services and are covered by New Hampshire Medicaid. These are noted in Table 1 using a √ symbol.

In New Hampshire, many of these CMS defined pre-tenancy and tenancy support services have the potential for alignment. Table 1 below outlines the supportive housing service and the corresponding health service that could potentially support Medicaid billing, using the ≈ symbol. Many of these services have potential for coverage if they are included in the individual's treatment plan or recovery plan, and if the individual is demonstrating active symptoms of mental illness during the time of the service.

Table 1: Services currently covered by NH Medical Assistance

SYMBOLS USED **√ : Aligned, service is currently covered** **≈ : Potential for coverage, state plan language doesn't explicitly cover service but may be covered if in client treatment plan**	**CMHC**	**FQHC**	**SUD**	**CFI Waiver**
Case Management/Care Coordination	√	√		√
Individual Counseling	√	√	√	
Medication Management	√	√		√
Pre-Tenancy: Outreach				
Pre-Tenancy: Conducting a screening and assessment of housing preferences/ barriers related to successful tenancy	≈	≈	≈	√
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	≈			
Peer Mentoring (Certified Recovery Workers for SUD can be peers or allies)	≈		≈	

B. State Plan Gaps

Some supportive housing services do not align with the current New Hampshire 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 been diagnosed with severe and persistent mental illness and qualify for targeted case management services through a CMHC or FQHC can potentially receive some supportive housing services from their case management provider, as long as it is medically necessary and included in their treatment plan. Additionally, individuals with intellectual and/or developmental disabilities are also eligible for some supportive housing services through the Choices for Independence Waiver.

> It should be noted that many of the covered services listed under Community Mental Health Centers (CMHC) are for Targeted Case Management services which require that the consumer have a diagnosis of a severe or persistent mental illness.

Supportive housing services have proven beneficial for improving the health outcomes, bettering care coordination and reducing system costs for other populations outside of those with diagnosed serious and persistent mental illness and intellectual/developmental disabilities. Within New Hampshire, supportive housing services are not currently covered through Medicaid for individuals with substance use disorders or for individuals with multiple unmanaged chronic health conditions who are homeless, despite the evidence-base promoting supportive housing as a valuable health benefit for these groups.

2. Gaps in Service Coverage

A large number of services that are a part of the package of evidence-based practices for supporting individuals to live successfully in supportive housing are considered gaps in services coverage as they are not yet explicitly included in New Hampshire's State Plan, its Amendments or Waivers as covered services for any groups.

- Pre-Tenancy Services
    - Outreach
    - Conducting a screening and assessment of housing preferences/ barriers related to successful tenancy
    - 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), moving costs and other one-time expenses
    - Ensuring housing unit is safe and 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

- Tenancy-Sustaining Support Services
    - 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
- Peer Support Services
- Transportation

3. Gaps in Access to Waiver Services

For providers serving individuals who are eligible for a Waiver program, opportunity exists to provide some supportive housing services. However, because waiver programs are not entitlement programs, a waiver program cannot guarantee that an individual need of services will receive services under the waiver. These individuals who apply for a waiver program and are not accepted due to client volume are placed on a waiting list. The waiting list for the Choices for Independence Waiver has been up to one year, in years past.

Qualifying for an HCBS waiver program, like Choices for Independence, does not guarantee that an individual will receive services under the waiver, as waiver programs are not entitlement programs and can have waitlists.

C. Provider Perceptions about Medicaid Coverage of Supportive Housing

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 four supportive housing providers in New Hampshire to learn the breadth and depth of services that 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 inconsistencies between Medicaid reimbursable services and provider perceptions of Medicaid reimbursable services.

Below is a summary of the interview findings and an analysis of the variation in responses across providers.

1. Summary of Services Provided by Supportive Housing Service Providers

The supportive housing providers interviewed for the Medicaid Crosswalk Report represented a range of provider types, including a Community Mental Health Center, a supportive housing services provider serving families and individuals with substance use disorders and chronic medical conditions, and supportive housing providers who are also providing shelter services and serving individuals with substance use disorders, mental illness, and multiple chronic medical conditions. The interviews determined that all of the providers interviewed provided the following services: care coordination; developing individualized housing support crisis plans; individualized service planning; referrals to other services and programs, together with monitoring and follow-up on these referrals; providing early identification and intervention for behaviors that may jeopardize housing; coaching on developing and maintaining relationships with landlords and neighbors; assisting with the housing recertification process; coordinating with tenant to review, update, and modify their housing support and crisis plans; continual training on tenancy and lease compliance; and providing transportation to medical and non-medical services.

> New Hampshire supportive housing providers are already offering, and have the expertise to offer, all supportive housing pre-tenancy and tenancy sustaining services, however, the current lack of sustainable services funding impacts their ability to meet current services need. Providers are currently unable to consistently offer all supportive housing services to all who are eligible for services and also struggle to meet fidelity case load requirements with current funding. Sustainable service funding through Medicaid is needed to bring this evidence-based practice to scale.

Additionally, most providers interviewed also provide these services: individual counseling; screenings and assessments of tenant's housing preferences and barriers related to successful tenancy; assisting with rent subsidy application and housing application processes; and assisting with the housing search process.

All providers agreed that they would like to provide all pre-tenancy and tenancy sustaining services identified by CMS. All providers also agreed that they would like to learn more about what services are currently covered as there was variation among provider perception of coverage.

2. Summary of Provider Perceptions of Medicaid Coverage for Supportive Housing Services

Providers were largely in agreement around what services were billable under targeted case management through Community Mental Health Centers (CMHCs), yet there were misunderstandings of covered services identified in the three service areas noted in the table below with an asterisk. These three services (screening and assessment of housing preferences, ensuring housing is safe, and assistance in resolving disputes with landlord or neighbors) all have potential for coverage under targeted case management, if the individual has a serious or persistent mental illness, has active symptoms, and has housing stability and healthy relationships as goals within their treatment plan. Table 2 (below) provides

additional details regarding provider perceptions of Medicaid coverage and how this coverage (or lack of coverage) compare to the services providers are currently funding through non-sustainable funding.

Table 2: Supportive Housing Provider Services and Perceptions of Medicaid Coverage

	Providers Offer Service	Details of Provider Perception on Coverage
Care Coordination	All Offer	CMHCs can bill under case management
Individual Counseling	Most Offer	Can be billed by a CMHC as counseling/therapy
Medication Management	Some Offer	CMHCs can bill under case management
Pre-Tenancy: Outreach	Few Offer	Not viewed as billable
Pre-Tenancy: Conducting a screening and assessment of housing preferences/ barriers related to successful tenancy	Most Offer	Not viewed as billable*[7]
Pre-Tenancy: Assisting with rent subsidy application/certification and housing application processes	Most Offer	CMHCs can bill under case management
Pre-Tenancy: Assisting with housing search process	Most Offer	Not viewed as billable
Pre-Tenancy: Identifying resources to cover start-up expenses (e.g., security deposits, furnishings, adaptive aides, environmental modifications), moving costs and other one-time expenses	Some Offer	Not viewed as billable
Pre-Tenancy: Ensuring housing unit is safe and ready for move-in	Some Offer	Not viewed as billable*
Pre-Tenancy: Assisting in arranging for and supporting the details of move-in	Few Offer	Not viewed as billable
Pre-Tenancy: Developing an individualized housing support crisis plan	All Offer, most require client signatures	CMHCs can bill under case management
Pre-Tenancy: Individualized Service Planning	All Offer, most require client signatures	CMHCs can bill under case management, or FFS counseling
Pre-Tenancy: Referrals to other services and programs	All Offer	Very few providers were eligible to bill for this service, as most providers interviewed were not CMHCs or FQHCs
Tenancy-Sustaining Support: Providing early identification/intervention for	All Offer	CMHCs can bill under case management, with medical necessity

[7] All items marked with an asterisk * are misunderstandings of covered services. These three services (screening and assessment of housing preferences, ensuring housing is safe, and assistance in resolving disputes with landlord or neighbors) all have potential for coverage under targeted case management, if the individual has a serious or persistent mental illness, has active symptoms, and has housing stability and healthy relationships as goals within their treatment plan.

behaviors that may jeopardize housing		
Tenancy-Sustaining Support: Education/training on the role, rights and responsibilities of the tenant and landlord	Some offer	CMHCs can bill under case management, with medical necessity
Tenancy-Sustaining Support: Coaching on developing/maintaining relationships with landlords/property managers	All offer	CMHCs can bill under case management, with medical necessity
Tenancy-Sustaining Support: Assisting in resolving disputes with landlords and/or neighbors	Some offer	Not viewed as billable*
Tenancy-Sustaining Support: Advocacy/linkage with community resources to prevent eviction	Some offer	Not viewed as billable
Tenancy-Sustaining Support: Assisting with the housing recertification process	All offer	CMHCs can bill under case management, with medical necessity
Tenancy-Sustaining Support: Coordinating with tenant to review/update/modify housing support and crisis plan	All offer	CMHCs can bill under case management, with medical necessity
Tenancy-Sustaining Support: Continuing training on being a good tenant and lease compliance	All offer	CMHCs can bill under case management, with medical necessity
Peer Mentoring	Some offer	Not viewed as billable
Transportation	All offer	Not viewed as billable

3. Provider Identified Gaps in Covered Services and Reimbursement

The majority of services that are covered or have potential to be covered by New Hampshire Medicaid must currently be provided by a Community Mental Health Center or Federally Qualified Health Center. Providers participating in the interview noted that supportive housing providers offer a valuable health intervention as they coordinate care between behavioral health and physical health providers, while also addressing housing need and social determinants of health related to housing stability. Delivering high quality supportive housing services, including pre-tenancy and tenancy support services, requires expertise in client engagement, outreach, and harm reduction possessed by supportive housing providers, yet it does not require masters level clinicians employed at CMHCs and FQHCs. As such, requiring that supportive housing providers become a CMHC or FQHC in order to provide pre-tenancy and tenancy support services adds an additional layer of financial and operational burdens not needed for ensuring fidelity to supportive housing. Providers also shared concerns about the lack of case management coverage for individuals with substance use disorders as their primary diagnosis, as well as the lack of case management and supportive housing coverage for high utilizers of emergency services who are homeless and living with multiple chronic medical conditions, such as diabetes, COPD, and hypertension.

Delivering high quality supportive housing services, including pre-tenancy and tenancy support services does not require masters level clinicians to provide direct services. Requiring that supportive housing providers become a CMHC or FQHC in order to provide pre-tenancy and tenancy support services adds unnecessary burdens to providers without additional benefits to clients.

CSH Recommendations

The state of New Hampshire is making strides to create an integrated system of care that meets the health needs of the whole person, addresses social determinants of health, and coordinates care across providers and systems to achieve better health for all residents. In order to realize the improved health outcomes and potential cost savings that result from Medicaid beneficiaries having access to supportive housing, CSH recommends the following for New Hampshire's leadership, providers, advocates, and consumers.

A. Create a Supportive Housing Services Benefit in New Hampshire's State Plan.

Supportive Housing Services should be explicitly included in the New Hampshire State Plan to align with CMS guidelines of pre-tenancy and tenancy-sustaining services included in its 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. Although multiple state plan amendments offer the opportunity to include these services in the state's benefit structure, the 1115 Waiver offers the greatest opportunity to comprehensively do so in a way that will reach the greatest number of people in need, there-by having the greatest impact possible on costs and health outcomes. Following is a brief comparison of three Medicaid Authorities that are best aligned with including supportive hosing 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	**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.

Under any authority an important consideration will be to ensure that providers who currently deliver high quality supportive housing have access to become licensed and contracted to deliver these services through the Medicaid system. Additionally, while supervision of behavioral health providers should be through licensed graduate level staff, supportive housing services delivered under these benefits can be successfully delivered by qualified bachelor's level staff with relevant supportive housing work experience or peer support specialists with lived experience.

B. Cover and expand supportive housing and 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 severe and persistent mental 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. The continuum of treatment options for households with substance use disorders must be expanded to include those that are homeless and actively using. Supportive housing services can improve the integration of behavioral and physical health care services and promote 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).

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 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 New Hampshire to better understand the cost savings potential supportive housing services could create. 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 (mentioned earlier in this report) to cover more rental subsidies and other non-billable supportive housing expenses.

D. Provide training to all stakeholder organizations on the role of supportive housing as a health intervention.

Training should be supported for all managed care organizations and traditional health and behavioral health organizations looking to learn more about the supportive housing services available for Medicaid clients. Managed care organizations can play a helpful role in facilitating shared learning and partnerships with the community-based agencies providing housing and supportive housing services for their members. Supportive housing services provide integrated care for the whole-person as care coordination involved all crisis service systems, including emergency services, primary and behavioral health care, housing and homeless system services and addiction treatment services. As such, all providers within these systems need to be included in training to support and promote care coordination efforts. It should be noted that supportive housing providers across the state have already been participating in training on how to better leverage Medicaid under the current system, through a CSH Medicaid Institute supported by Housing Action New Hampshire and funded by the Endowment for Health.

With state-wide Medicaid training underway for supportive housing providers and coordination efforts beginning between health and housing providers around the 1115 Transformation Waiver, New Hampshire is well positioned to continue their service system integration efforts. As supportive housing is increasingly promoted as an evidence-based health intervention through managed care and State Medical Assistance, New Hampshire will see increased success in meeting its goal of integrating care systems and delivering the right care at the right time to the people who need it most.