



Medicaid Supportive Housing Services Crosswalk

NORTH CAROLINA, 2020



About CSH



CSH is the national champion for supportive housing, demonstrating its potential to improve the lives of very vulnerable individuals and families by helping communities create over 335,000 real homes for people who desperately need them. CSH funding, expertise and advocacy have provided \$1 billion in direct loans and grants for supportive housing across the country. Building on nearly 30 years of success developing multi and cross-sector partnerships, CSH engages broader systems to fully invest in solutions that drive equity, help people thrive, and harness data to generate concrete and sustainable results. By aligning affordable housing with services and other sectors, CSH helps communities move away from crisis, optimize their public resources, and ensure a better future for everyone. Visit us at csh.org.

About Alliance Health



Alliance is a Local Management Entity (LME), as well as a managed care organization (MCO), for public behavioral healthcare for the citizens of Durham, Wake, Cumberland, and Johnston counties in North Carolina. In North Carolina, these entities are known as LME-MCOs. Although not a direct provider of services, they develop and manage a network of provider organizations that serves individuals who need behavioral health services. They ensure quality in their network so that those individuals seeking help receive the superior services necessary to achieve their goals and live as independently as possible. The Alliance closed Provider Network is a diverse network of over 2,000 private behavioral healthcare providers who are incorporating evidence-based practices that are proven to lead to healthier lives for the people served.

Acknowledgements

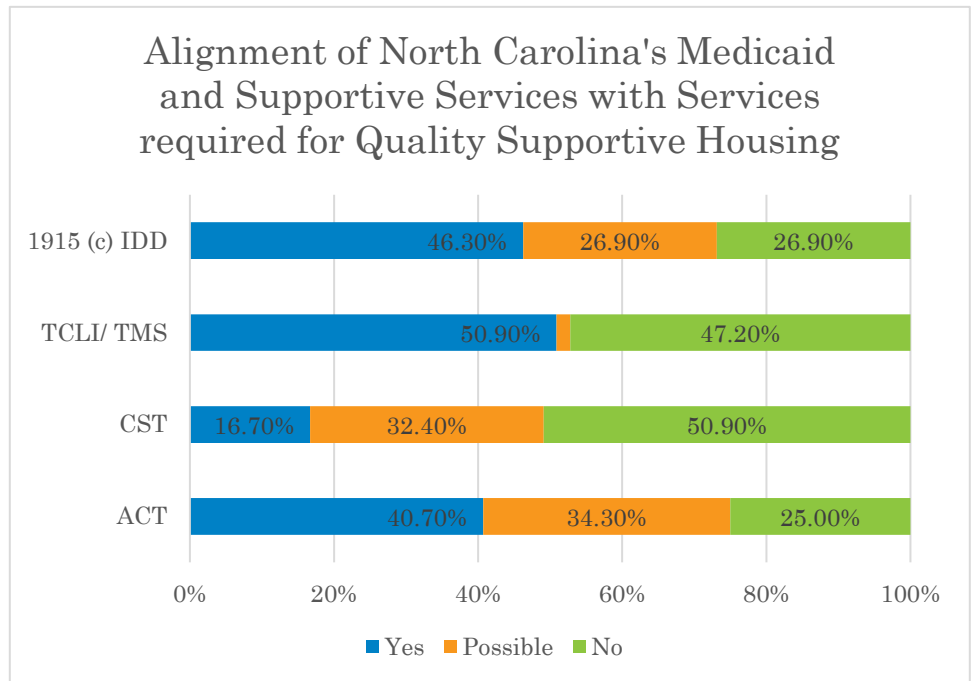
CSH would like to acknowledge and thank Alliance for their funding and support for this research and corresponding report. Ann Oshel led the efforts from Alliance and Jeffrey Payne also contributed key information. CSH would also like to acknowledge the North Carolina Department of Health and Human Services, in particular, staff members Deborah Goda, Katherine Nichols, and Angela Harper King. Additionally, CSH would like to recognize service provider agency staff members who provided guidance and clarification on day-to-day operations of direct program services; including Katie Wright of Carolina Outreach, Wes Caldwell and Paul Boissoie from Easter Seals UCP of Raleigh, and Bagé Shade from Triangle Family Services. Finally, the team would like to thank Marti Knisley, Independent Reviewer for North Carolina's Olmstead Settlement Agreement, for her guidance and support.

EXECUTIVE SUMMARY

CSH conducted a North Carolina Medicaid Services and Supportive Housing Crosswalk (Crosswalk). Recognizing the positive impacts supportive housing can have on individuals' health and well-being, housing stability, and healthcare utilization, the Crosswalk examines the extent to which supportive housing services align with existing benefits covered by North Carolina's Medicaid program and state funded community-based services that align with housing. The full report consists of four parts including a background and definitions section; an overview of key aspects of North Carolina's Medicaid and other state services program; the Crosswalk results, which provide a summary of key areas of alignment and gaps found in covered services, as well as interview results from supportive housing and healthcare provider agencies; and finally, CSH's recommendations for the steps North Carolina could consider to ensure quality and accountability in their services and maximize Medicaid revenue to reimburse for supportive housing services that enable individuals to live successful, stable lives in their communities. This Executive Summary reviews key findings and recommendations found in the full report.

Key Findings

Supportive housing services include housing transition services, pre-tenancy and tenancy sustaining services, and care coordination services. The Centers for Medicare and Medicaid Services (CMS) released a State Health Official letter in January 2021, which outlined definitions of pre-tenancy and tenancy support services that were eligible for Medicaid coverage. Using CMS approved services and definitions, CSH compared these pre-tenancy and tenancy support services and other supportive



housing wraparound services to the Delaware Medicaid State Plan, including their collaboration with Managed Care, and the use of other state services. CSH found areas of direct alignment, potential for alignment, and gaps.

Alignment

Many of the services in North Carolina's behavioral health community-based services can be used as the 'supportive services' in supportive housing. The state's Transition to Community Living Services, as part of the state's Olmstead settlement, offers to a discrete group of individuals many of the services required for quality supportive housing. The state has also recently revised the service definition for Assertive Community Treatment and Community Support teams to include a variety of housing related services.

What Isn't Covered – Gaps Identified in the Crosswalk Analysis and Key Interviews

Some supportive housing services do not align with North Carolina's services. Five main gaps were identified:

- Gaps in populations served, notably: housing related services are available but only for those with the most acute needs, such as those that qualify for the TCLI program, ACT program, or have an intellectual disability and are transitioning from an institution;
- Gaps in core supportive housing services, including support for families. This is common as few Medicaid programs cover these services and those that do have only added those services in recent years;
- Gaps in behavioral health provider's understanding of supportive housing and best practices while working with people experiencing homelessness;
- Gaps in supportive housing provider's capacity, understanding of Medicaid benefits, and understanding of the infrastructure needed to bill Medicaid; and
- Gaps in information and data needed to effectively manage and develop the program to address evolving needs.

Supportive Housing Provider Interviews

The Crosswalk review also included interviews with service providers from across the State to better understand 1) the range of supportive housing services currently offered by providers, 2) the current funding sources for these services, and 3) the perceptions supportive housing providers have about Medicaid coverage. Interviews identified that providers and Managed Care Organizations involved in supportive housing programs vary in how they identify their roles and responsibilities related to delivering core supportive housing services, and as such, supportive housing services vary in intensity, duration, and focus, and are often provided through several providers with varying levels of coordination. Providers interviewed expressed a desire to expand and improve supportive housing services to better serve their service participants. For providers operating outside of a Medicaid environment, an interest in learning more about Medicaid as a revenue source was coupled with hesitation around potential infrastructure and administrative requirements.

Recommendations

1. Capitalize on the opportunity of the State's 1115 Waiver.
2. Develop statewide standards and expand training and coaching for providers who are required to offer quality supportive housing and services.
3. Create a supportive housing services benefit in North Carolina's state plan through a 1915(i) State Plan Amendment or SPA.
4. Map how Home and Community Based Services (HCBS) are accessed in North Carolina and what barriers remain to accessing services for vulnerable populations.
5. Evaluate cost savings and redirect those shared savings back to Behavioral Health and Housing systems.

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INTRODUCTION

In partnership with Alliance, CSH conducted a Supportive Housing Services Crosswalk to show how North Carolina can increase its supportive housing capacity through Medicaid and state funding. The Medicaid Supportive Housing Services Crosswalk examines the extent to which North Carolina'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 North Carolina can take to maximize Medicaid to pay for supportive housing services.



MEDICAID EXPANSION

North Carolina has not yet expanded Medicaid. In 2019, 18% of residents were covered by Medicaid and CHIP across the state. Kaiser Family Foundation estimates that 215,000 poor, uninsured, nonelderly adults were in the ACA coverage gap.¹

¹ <http://files.kff.org/attachment/fact-sheet-medicaid-state-NC>

I. SETTING THE STAGE: BACKGROUND AND DEFINITIONS

In North Carolina, as in other states, a small yet noteworthy group of residents have critical, unmet housing and healthcare needs.² Many of these highly vulnerable individuals are living with multiple chronic health conditions and behavioral health challenges, including serious mental illness, substance use disorders, and intellectual and developmental disabilities. The state has recognized many of their non-Medical needs through its emphasis on Social Determinants of Health and its Healthy Opportunities Pilots.³ Most of these people have extremely low incomes and 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 appropriate level of care they need in community settings and therefore are not experiencing improved health outcomes. Instead, they experience expensive and often preventable institutionalization, a lack of access to primary care, a lack of community integration and a lack of service coordination to address co-occurring disorders and co-morbidities.

Since 2012, North Carolina has been under an Olmstead Settlement Agreement and has focused its supportive housing capacity to address the issues raised by the lawsuit.⁴ The priority populations for the purposes of the settlement agreement are persons with Serious Mental Illness who are living in large Adult Care Homes. With limited resources dedicated to supportive housing, the settlement has driven the majority of housing resources to the settlement population with limited access to other populations. This policy environment has left those with complex care needs and those experiencing homelessness with far too limited access to the evidenced based practice of supportive housing. In addition, North Carolina has been challenged to create sufficient capacity, even to address the needs of the Olmstead target population. While these residents represent a small percentage of the total state population, that population is increasing and will soon represent a greater percentage of individuals with serious and persistent mental illness. Their healthcare costs currently constitute a disproportionate percentage of North Carolina's expenditures and will grow significantly over the next few years.

A. People Experiencing Homelessness in North Carolina

Every other year, communities across the nation who receive Homelessness Assistance Funds from the federal Department of Housing and Urban Development (HUD) are required to conduct a count of people experiencing homelessness, known as the Point in Time Count (PIT). Data from the PIT counts offers perspective on many issues, including changes in the number of people experiencing homelessness, the percent of people experiencing unsheltered homelessness, and the household and demographic makeup of individuals and

² <http://pulse.ncpolicywatch.org/2018/06/26/north-carolina-advocates-health-care-leaders-press-again-for-medicaid-expansion/>

³ <https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/healthy-opportunities-pilots>

⁴ <https://www.ada.gov/olmstead/documents/nc-settlement-olmstead.pdf>

families experiencing homelessness. CSH used data from the North Carolina Coalition to End Homelessness⁵ to highlight trends in the number of people in North Carolina experiencing homelessness and to highlight the disproportionate representation of people of color experiencing homelessness in North Carolina. Figure 1 highlights the number of people experiencing homelessness during the 2019 PIT count, the most recently available data. As a PIT count, this number represents one day; however, communities know that people fall into and out of homelessness every day. Using data from the PIT count, the Coalition estimates 27,900 persons will experience homelessness in North Carolina in 2019. The report estimates a .5% increase between 2018 and 2019.



Figure 1: Point in Time Homelessness Count results⁶

EQUITY ANALYSIS

Nationally, due to the long-term impact of systemic and institutional racism, Black Americans experience significantly higher rates of homelessness – while 13% of the population, Black Americans are 40% of the people experiencing homelessness.⁷ In North Carolina, Black Americans are 22% of the population⁸, yet 52% of those experiencing homelessness.⁹ As in most states, Black Americans are overrepresented among those experiencing homelessness. Supportive housing can be a powerful tool in addressing racial disparities in health, economic mobility, and homelessness, as it provides the platform for people to experience safety and stability, affordable housing, access to transportation, better access to healthcare, and ultimately the ability to live fuller, healthier lives.

B. 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).

⁵ <https://www.ncceh.org/>

⁶ <https://www.ncceh.org/media/files/files/7bd752c5/2019-nc-pit-infographic.pdf>

⁷ <https://www.hudexchange.info/homelessness-assistance/racial-equity/#covid-19>

⁸ <https://www.census.gov/quickfacts/NC>

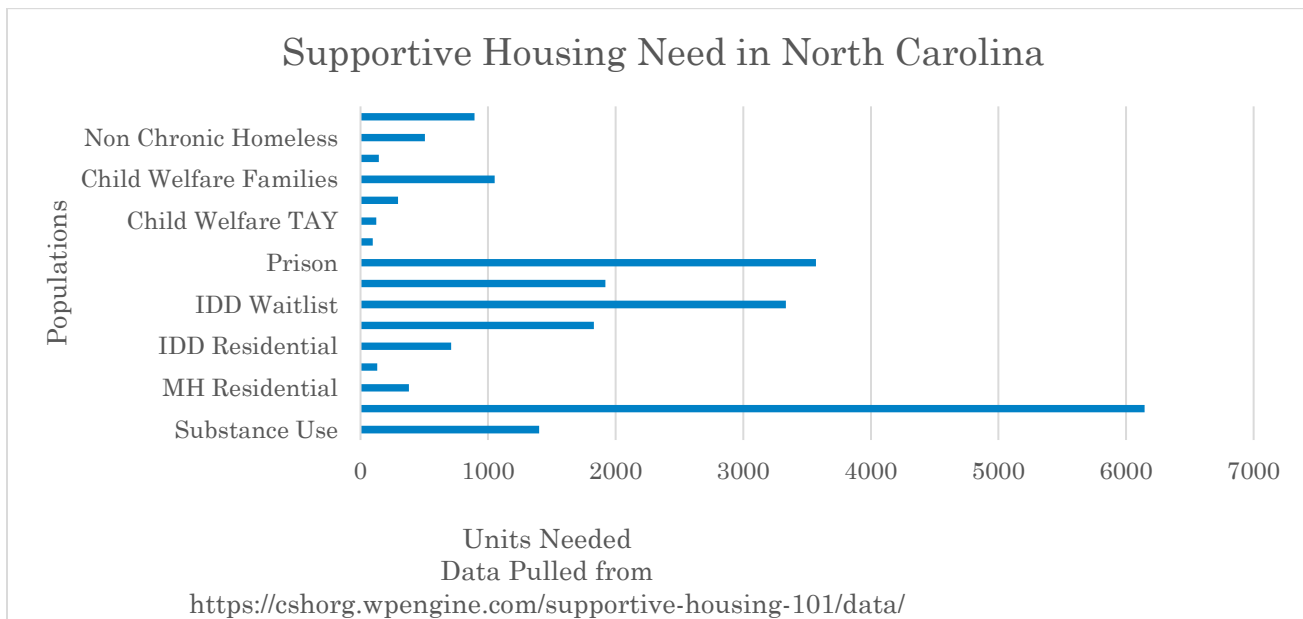
⁹ https://files.hudexchange.info/reports/published/CoC_PopSub_State_NC_2019.pdf

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 supported services. 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 work to coordinate care with other community providers and are often the link for tenants to connect with 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 tenants in supportive housing.

The homelessness response system fully embraces supportive housing as a best practice for ending homelessness for those with significant disabilities, but the homelessness sector 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.

CSH estimates that the Supportive Housing Need for North Carolina is approximately 22,250 supportive housing units to address the unmet need in the community. This includes units for persons who have significant behavioral health challenges, persons who are aging, persons experiencing homelessness, and a variety of other populations. A chart summarizing those populations can be found in Figure B.

FIGURE B



C. Medicaid

Medicaid, often referred to as Medical Assistance, is public health insurance that pays for essential medical and medically related services for categorically eligible individuals with low incomes. To date, thirty-seven states have expanded Medicaid to include all individuals with low incomes. North Carolina is among the fourteen states that have not yet expanded Medicaid to include individuals with low incomes who do not have a disability that has been proven to the state. The Division of Health Benefits (DHB) oversees the Medicaid program in North

Carolina. DHB views individuals as automatically eligible¹⁰ for Medicaid in North Carolina if they currently receive Supplemental Security Income (SSI), Work First Cash Assistance, or State/County Special Assistance for the Aged or Disabled. Statutorily, Medicaid insurance cannot pay for room and board directly. Once an eligible individual is enrolled, Medicaid's ability to reimburse for services starts with a determination as to whether the services are medically necessary.

D. 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.¹¹ 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 rehabilitation¹² option, the service must meet the purposes of "reducing disability and restoring function."¹³

E. Medicaid Waivers and State Plan Amendments

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, and people living with traumatic brain injuries). These services are designed to serve people in their own homes and communities rather than in institutions.

F. 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, credentialing requirements, and staff qualifications that determine which providers can receive

¹⁰ <https://dma.ncdhhs.gov/medicaid/get-started/eligibility-medicaid-or-health-choice>

¹¹ For more detail on mandatory and optional Medicaid benefits - <https://www.medicaid.gov/medicaid/benefits/list-of-benefits/index.html>

¹² 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>.

¹³ Wilkins, C., Burt, M., and Locke, G. (July 2014). A Primer on Using Medicaid for People Experiencing Chronic Homelessness and *Tenants in Permanent Supported Housing*. Page 32. Available at: <http://aspe.hhs.gov/daltcp/reports/2014/PSHPrimer.cfm>.

Medicaid reimbursement. Many MCOs aim to reimburse providers within 30 days of the provider submitting a claim. Alliance has a variety of roles in the Healthcare delivery system in the four communities in which they are located. Behavioral Health services are reimbursed by Local Managing Entities (LMEs), which is described in more detail below. Alliance Health, along with other agencies covering different regions across the state, are referred to as LME-MCOs.¹⁴

II. MEDICAID IN NORTH CAROLINA AND THE MEDICAID STATE PLAN

Medicaid in North Carolina is in a state of transition. The program is administered by the North Carolina Department of Health and Human Services (the Department) through North Carolina Medicaid in the Division of Health Benefits (DHB). Individuals are eligible for Medicaid in North Carolina if they have low incomes and meet categorical requirements. Eligible individuals include those with low incomes who are parents, children, seniors, and people with disabilities. North Carolina Medicaid deems individuals as automatically eligible for Medicaid in North Carolina if they currently receive Supplemental Security Income (SSI), Work First Cash Assistance, or State/County Special Assistance for the Aged or Disabled. If North Carolina chooses to expand Medicaid, then only a low income will be needed to qualify. Medicaid expansion is hot button political issue in North Carolina in 2021, with the American Rescue Plan (ARP) offering enhanced Federal Medical Assistance Percentage (FMAP) rates for states that choose to expand now.

Currently, the Department has separate payment and delivery systems for physical health services and behavioral health and intellectual/developmental disability (I/DD) services. The state is transitioning from primarily a fee-for-service to a predominantly managed care system. In 2021, North Carolina is contracting with prepaid health plans (PHPs) to deliver all services under a full risk-based capitation model. A few statutorily mandated carve-outs from the managed care program will remain.¹⁵ North Carolina has noted their intent to contract statewide with AmeriHealth Caritas, Blue Cross and Blue Shield of North Carolina, UnitedHealthcare and Wellcare.¹⁶ As of January 2020, Wellcare has been acquired by Centene.¹⁷ Carolina Complete Health, a provider led partnership will serve Medicaid members in two regions of the state.¹⁸ The goal of the PHPs, now called “Standard Plans,” will be to deliver a comprehensive set of benefits, integrating physical and behavioral health. The PHPs will be required to provide services in the current Medicaid fee-for-service State plan, use the state definition of “medical necessity” in making coverage decisions, and use the State’s Preferred Drug List. The Standard Plans will not commonly serve persons with significant behavioral health challenges, rather the state has received proposals from the current LME-MCOs such as Alliance to operate as “Tailored Plans” that will specialize in coverage for individuals with significant behavioral health challenges.¹⁹ These Tailored Plans will cover physical health, Behavioral Health (BH) services, specialized services for persons with Intellectual and

¹⁴ <https://www.ncdhhs.gov/providers/lme-mco-directory>

¹⁵ The carve-out services include but are not limited to dental services; services provided through the Program of All-Inclusive Care for the Elderly (PACE); audiology, speech therapy, physical therapy, nursing and psychological services documented in an individualized education program (IEP) and provided or billed by the local education agencies; services provided and billed by a children’s developmental services agency (CDSA) that are included in the child’s individualized family service plan; and services for Medicaid applicants provided prior to eligibility determination in cases where retroactive eligibility is approved. https://files.nc.gov/ncdhhs/documents/Benefits-CCP_ConceptPaper_FINAL_20180302.pdf

¹⁶ <https://medicaid.ncdhhs.gov/blog/2019/03/01/managed-care-providers-php-contracts-awarded>

¹⁷ <https://www.centene.com/news/centene-completes-acquisition-of-wellcare.html#:~:text=Centene%20is%20pleased%20to%20have,new%20chapter%20in%20our%20story.>

¹⁸ <https://www.ncdhhs.gov/news/press-releases/dhhs-announces-prepaid-health-plan-contracts-medicaid-managed-care>

¹⁹ <https://files.nc.gov/ncdhhs/State-funded-Services-Policy-Paper-20191230.pdf>

Developmental Disabilities (I/DD) and specialized for persons who have suffered a Traumatic Brain Injury (TBI) under an integrated financial model. Persons with these disabilities can choose a Standard Plan if they so wish as long as they are NOT on a TBI or Innovations waiver program. Persons served by those waivers will be required to be served by the Tailored Plans.

This Crosswalk report includes a review of North Carolina's Medicaid State Plan, relevant State Plan Amendments (SPAs) and Waivers, its 1115 Transformation Waiver, and other relevant state-funded services for people living with behavioral health needs, intellectual and developmental disabilities, and substance use disorders.

A. Managed Care in North Carolina

North Carolina is in a period of transition in relation to its health care delivery system. Historically, the program was based on a Primary Care Case Management (PCCM) model, managed by Community Care of North Carolina ACCESS. The PCCM model provides physical health care management services. Under this program, eligible beneficiaries join medical homes, which coordinate a patient's health care services. The medical home will serve patients with mild behavioral health needs. The specialty Behavioral Health system (LME-MCOs) offers care coordination services for special populations including persons with Behavioral Health (BH) challenges, persons with Intellectual and Developmental Disabilities (I/DD) and persons who have suffered a Traumatic Brain Injury (TBI). In some communities, these responsibilities are shared between the medical home and the LME-MCOs.

Local management entity-managed care organizations (LME-MCOs) deliver behavioral health, I/DD and TBI services. The LME-MCOs have standardized delivery of services including managed behavioral health, I/DD and TBI service costs. There are seven LME-MCOs operating in the state. LME-MCOs contract with local community service providers to deliver the services. LME-MCOs receive a monthly capitated payment based on the number of Medicaid beneficiaries residing in their catchment area from the Department to manage mental health, substance use and I/DD services to Medicaid beneficiaries. The LME-MCOs also manage the Transitions to Community Living Initiative (TCLI), a program created by the legislature to respond to a court ordered settlement for individuals with serious mental illness who are residing in Adult Care Homes or can be diverted from Adult Care Homes. The LME-MCOs also manage the Innovations IDD waiver that will be discussed further along in the paper. Alliance LME-MCO also manages the Traumatic Brain Injury Waiver (TBI Waiver), though only for the counties (Cumberland, Durham, Johnston, and Wake) that they serve. In addition, the LME-MCOs offer care coordination and case management services for members with complex care needs.

In addition to serving individuals enrolled in Medicaid, LME-MCOs are also required to serve the uninsured through state funding and federal block grant funds. These funds, called "single stream funding" are allocated by the state legislature on an annual basis. The single stream funding is used to support individuals who are uninsured or underinsured. These state-funded services are not an entitlement, and state requirements for services offered and persons served remain constant. This leads to challenges to long-term program sustainability as funding remains flat. One advantage with the state funds, however, is that the LME-MCOs can use them to pay for tenancy supports, which is explicitly included in the CST definition as of October 1, 2019.

Standard plan Managed Care implementation is on schedule to begin in July 2021.²⁰ Tailored Plan implementation is projected to begin a year later in July 2022.

²⁰ <https://healthpayerintelligence.com/news/nc-starts-medicaid-transformation-program-sidesteps-expansion>

Services in North Carolina's State Plan: *Mental Health Services*

In North Carolina, LME-MCOs provide mental health services through contracts with local community providers. The LME-MCOs are supported via a mix of Medicaid, federal block grant, and state only funds. Medicaid beneficiaries receive mental health, substance use, and intellectual and developmental disability services through the LME-MCOs. The state also requires the LME-MCOs to serve the uninsured through non-Medicaid funding sources.

Numerous behavioral health philosophies, models, and services are relevant to housing support services, including:

Integrated Dual Disorder Treatment (IDDT)

The IDDT model is an evidence-based practice that improves the quality of life for people with co-occurring severe mental illness and substance use disorders by combining substance abuse services with mental health services. It helps people address both disorders at the same time, in the same organization, by the same team of treatment providers. Use of the treatment philosophy helps persons with co-occurring disorders access evidence-based treatment. Since persons with co-occurring disorders are overrepresented among people experiencing homelessness and housing instability, offering integrated care is essential to assisting in assuring housing stability.

Assertive Community Treatment (ACT)

The ACT team model includes psychiatrists, nurses, social workers, substance abuse specialists, vocational specialists, certified peer support specialists, and other specialized staff who help adult individuals with severe and persistent mental illness live in their homes instead of institutions. The LME-MCOs contract with local providers to deliver ACT services. There is a case rate funding model for ACT services in North Carolina that includes Medicaid funding and state funding. Medicaid funds the services for persons who are Medicaid eligible, while state funding is used for persons who are not Medicaid eligible. Providers make the case for medical necessity with the LME-MCO. ACT service definitions were updated in December 2019 and a major change was the inclusion of tenancy support services, as part of the ACT team role.²¹

Community Support Team (CST)

CST services consist of community-based mental health and substance abuse rehabilitation services and necessary supports provided through a team approach to assist adults in achieving rehabilitative and recovery goals. CST is a Medicaid State Plan service. Of note, persons with solely an SUD diagnosis are eligible for CST services as that is not common in many states. CST is designed to reduce presenting psychiatric or substance abuse symptoms and promote symptom stability, restore the individual's community living and interpersonal skills, provide first responder intervention and deescalate the current crisis, and ensure linkage to community service and resources. The CST service definition was amended effective October 1, 2019, to add tenancy support activities and a peer support component.²² Additional individuals will be able to access this service due to changes in the eligibility policy that adds "homeless or at high risk of homelessness" as a potential criterion for services eligibility. For eligibility, persons must have a documented behavioral health diagnosis, documented significant impairment in two or more life domains, and is able to develop the skills to address these impairments. The person's homelessness should be due to residential instability resulting from the beneficiary's mental health

²¹ <https://files.nc.gov/ncdhhs/documents/files/State-Funded-ACT-Policy-12-15-19.pdf>

²² https://files.nc.gov/ncdma/documents/files/8A-6_0.pdf

or substance use disorder diagnosis, or if their behavioral health challenges cause difficulty in sustaining a safe stable living environment.

Historically, CST services could initially only be provided for 6 months, although providers could request of the LME-MCOs additional reauthorizations for another 6 months, up to 18 months maximum. With the new CST definition, the LME-MCOs have more flexibility to authorize this service as medically necessary. The service is used as an intervention to avoid need for a higher level of care (ACT) or as a step down from a higher level of care, such as ACT. CST services are funded through Medicaid or state funding.

Individual Placement and Supports/Supported Employment (IPS/SE)

IPS/SE is an evidence-based practice that helps people with severe illness work at regular jobs of their choosing. Supported employment is available currently through the (b)(3) waiver, the Innovations waiver for persons with I/DD, the TBI waiver, single stream funding for persons with SMI and state vocational rehabilitation funding. As part of the (b)(3) services, the LME-MCOs are responsible for an individual's access to IPS/SE services. In the new delivery systems, these services will be available through the Tailored Plans. Supported Employment is also available through the Department of Vocational Rehabilitation Services, and a person may self-refer or be referred by a friend, family member, or a provider. IPS/SE is a person-centered service with a focus on employment that provides assistance in choosing, acquiring and maintaining competitive paid employment in the community for individuals 16 years and older for whom employment has not been achieved or employment has been interrupted or has been intermittent. The IPS-SE team must work with a behavioral health provider, either through contract or with a staff member in the IPS-SE agency.

To be eligible, an individual must:

- 1) have a primary diagnosis of serious mental illness that includes a severe and persistent mental illness and co-occurring disorders, which may be a primary substance abuse diagnosis; AND
- 2) experience difficulties in at least two or more of the following areas:
 - they are in, or at risk of being placed in, a congregate setting, or have difficulty maintaining safe living situations, including homelessness;
 - they have co-occurring mental health and substance abuse disorders;
 - they are at high risk of crisis diversion and/or intervention, including hospital transitions;
 - they have difficulty effectively using traditional office-based outpatient services;
 - they have difficulty with daily living, communication, interpersonal skills, self-care, self-direction;
 - they are at high risk or have a recent history (within the past 12 months) of criminal justice involvement (such as arrest, incarceration, probation); AND
- 3) express the desire to work; have an established pattern of unemployment, underemployment, or sporadic employment; and require assistance in obtaining or maintaining employment in addition to what is typically available from the employer because of functional limitations as described above and behaviors associated with the individual's diagnosis.

There is a zero-exclusion criterion, meaning individuals are not disqualified from engaging in employment simply as a result of job readiness factors such as active substance use, history of violent behavior, criminal background issues, cognitive impairments, treatment or medication non-compliance, or personal presentation.

Transitions to Community Living Initiative (TCLI)

TCLI provides eligible adults living with serious mental illnesses the opportunity to choose where they live, work, and play in North Carolina. This state-funded initiative was created to respond to a settlement agreement between the state and the Department of Justice to settle a lawsuit brought by the Department of Justice based

on the Olmstead decision. Individuals with SMI or SPMI who are current adult care home residents or who are discharged from state hospitals, and individuals who are diverted from or discharged from adult care homes and who were homeless or will return to unstable housing or homelessness are eligible for TCLI services and housing. Currently there are more than 12,000 persons in the statewide database who qualify for the services. The LME-MCOs manage the TCLI services.

TCLI has six primary components and LME-MCOs are either responsible for managing a provider network that delivers the following services or performing the noted function themselves:

- In-reach and Transition – Providing or arranging for frequent education efforts and discharge planning targeted to individuals in Adult Care Homes (ACHs) and state psychiatric hospitals. These services are financed as an administrative function of the LME-MCOs that are state funded. Inclusion of these services are calculated into the LME-MCO's rate development. The state budget includes line items for TCLI services that are allocated to the LME-MCOs.
- Pre-Screening and Diversion – Providing informed choice regarding housing options to individuals with SMI or a Serious and Persistent Mental Illness (SPMI) as requested by eligible participants and as noted on the participants community integration plan. LME-MCOs are required by the Olmstead Settlement agreement to actively offer all community options. As of November 1, 2018, these activities are the full responsibility of the LME-MCOs.
- Permanent Supportive Housing – Providing community-based supportive housing with tenancy supports and housing operating subsidies. Housing rental subsidies are currently primarily a tenant based rental subsidy funded by the state. There are no time limits on the subsidy. The state has budgeted funding to the LME-MCOs to meet the terms of the settlement agreement including these subsidies. The program has grown \$7 million a year over the last two years to address the needs of new program participants. Despite these supports, a variety of factors have created high turnover in the program, and costs related to turnover have not been built into the current budgeting process.
- Supported Employment – An evidence-based practice to assist individuals in preparing for, identifying, and maintaining integrated, paid, and competitive employment. The program is funded by Medicaid, state funding, and Vocational Rehabilitation (VR) funding.
- Assertive Community Treatment – An evidence-based treatment and support model of services offering intensive customized, community-based services for people with mental illness. This program is supported by Medicaid and state funding.
- Quality management – Using data to evaluate progress and outcomes. This program is an LME-MCO administrative function.

Each component has milestones set by the settlement agreement. In order to be eligible, all individuals must be screened through by the LME-MCO to determine whether the individual has SMI or SPMI and meets other TCLI criteria. State DMH/DD/SAS staff makes the final determination of eligibility.

Transition Management Services (TMS) is a state-funded service provided to individuals participating in TCLI.²³ TMS is a rehabilitation service intended to increase and restore an individual's ability to live successfully in the community by assisting them to obtain and maintain housing. TMS was previously known as Tenancy Support Team. Providers of TMS must, among other things, meet provider qualifications established by NC DMH/DD/SAS; be certified by an LME-MCO; and become a legally constituted entity capable of meeting all of the requirements of the Provider Certification and LME-MCO Enrollment Agreement.

²³ <https://files.nc.gov/ncdhhs/Transition%20Management%20Services-Final%20for%20Posting%206-3-16.pdf>

Tenancy support services were noted as part of the Housing section of the settlement agreement, NOT the services section. For the past 4 years, the state has funded the LME-MCOs a service allocation and has directed a specific service description for which these funds are to be used. The program is benchmarked to the state housing funding. As of October 1, 2019, CST services now formally include tenancy support components. The TMS services will remain to serve uninsured and underinsured individuals. Both programs will work to assist vulnerable populations remain in stable housing. The state has recently received approval from CMS for their revised State Plan Amendment that adds these tenancy supports components to the CST definition.

For those eligible individuals currently residing in adult care homes, the LME-MCOs do in-reach into the facilities to explain the community-based mental health services, supportive housing options, and the availability of tenancy support services and rental assistance. There are transition coordinators to support individuals who decide to transition from adult care homes to community-based living options.

In the community, the goals of the LME-MCOs and the Olmsted settlement agreement are building towards a system in which mental health services are evidence-based and recovery-oriented. TCLI uses Assertive Community Treatment (ACT) services model, as well as the Individual Placement and Support-Supported Employment (IPS-SE) model that helps individuals with severe mental illness work at regular jobs of their choosing.

In addition to individuals with SMI and SPMI who are currently residing in adult care homes, the settlement mandates that the state serve those who meet the diagnostic criteria but who are “at risk of entering an adult care home.” The determination must be based on documentation of factors that would indicate that an individual with an SMI or SPMI is living in an unstable or tenuous environment and are being considered for adult care home placement without the intervention of mental health services and supports.²⁴

The state will begin awarding incentives to PIHPs upon the successful transition of members of the target population to home and community-based residences.

Targeted Case Management

North Carolina has a State Plan Amendment for Targeted Case Management Services for persons with serious mental illness, substance use disorders,²⁵ and/or HIV. The case managers conduct a comprehensive assessment and evaluate an individual's need for initial case management services. The assessment shall address coordination and follow-up of medical treatments; provision of treatment adherence education; physical needs to include activities of daily living and instrumental activities of daily living; housing and unmet needs related to the physical environment; and socialization and recreation needs. The case manager develops a care plan and then refers and helps the individual to obtain the needed services. For persons with MH or SUD disorders, prior approval for services is required, may only be provided by agencies certified as a Critical Access Behavioral Health Agency (CABHAs), and is envisioned as a short-term service with an initial authorization period of 90 days and up to 60 days thereafter. For persons with HIV, the services are limited to four hours a month and a physician must submit a written order that details an individual's need for the service.

B. Fee for Service Reimbursement in North Carolina

In addition to managed care, North Carolina also operates a fee for service (FFS) reimbursement system for certain populations and certain services. Populations covered include behavioral health services for children age 0-3 and legal aliens. Services covered include certain basic mental health services provided through independent

²⁴ <https://files.nc.gov/ncdhhs/documents/files/RSVP-FAQ-updated-10-1-18.pdf>

²⁵ <https://files.nc.gov/ncdma/documents/files/8-L.pdf>

mental health individual providers such as independent Licensed Clinical Social Workers or psychiatrists. This FFS program also serves those individuals who do not qualify for Managed Care or services through the LME-MCOs. 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.

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. Some basic treatment for substance abuse disorders is provided in the FFS system by primary care providers. Individuals can receive office-based medication management under FFS but if individuals required more intensive treatment, they would have to seek treatment through the LME-MCO.

C. North Carolina's Medicaid Waiver Authorities

1. Waiver Services to support persons who are developmentally delayed or intellectually disabled.²⁶

The NC Waiver that provides supports to persons with developmental or intellectual disabilities is the NC Innovations Waiver (0423.R02.00). The Innovations Waiver provides an array of services to assist persons so they can remain in the community, including day supports, personal care, respite, residential supports, and supported employment. The North Carolina Innovations Waiver is managed by the LME-MCOs. The waiver targets individuals with I/DD, provides individual support planning, and links participants to necessary supports and services. Individuals on the waiver have access to a variety of supports and services in addition to the State Plan Medicaid Services. There are more than 13,000 slots for individuals who qualify for waiver services, with a large waiting list for slots in the waiver. For example, Alliance covers four counties in North Carolina and has 1,945 people receiving waiver services currently and approximately 3,000 persons who qualify and are waiting for waiver services. Individuals on the waiver waiting list have access to the usual array of state plan and LME services.

2. Waiver Services for Aged and Disabled – NC CAP/DA waiver

This waiver is for individuals age 65 and older, or who are physically disabled and age 18-64. The waiver provides the following services: adult day health, case management, institutional respite services, personal care aide, care advisor, financial management services, personal assistance services, assistive technology, community transition services, home accessibility and adaptation, meal preparation and delivery, non-institutional respite services, participant goods and services, personal emergency response services, specialized medical equipment and supplies-nutritional supplements, specialized medical equipment and supplies-reusable incontinence supplies, specialized medical equipment and supplies – disposable liners, specialized medical equipment supplies-medication dispensing boxes, training/education, and consultative services. These services are intended to allow aged and disabled individuals to remain in the community.

3. Medically Fragile Waiver – NC Children's Alternatives Program

This waiver provides services for individuals who are medically fragile from ages 0-20. Services include in-home care aide service, financial management, assistive technology, case management, community transition, home accessibility and adaptation, institutional and non-institutional respite, participant goods and services, pediatric nurse aide services, specialized medical equipment and supplies, training, education and consultative services, and vehicle modification. These services are intended to allow individuals to live in home and community-based settings.

²⁶ <https://medicaid.ncdhhs.gov/nc-innovations-waiver>

4. NC TBI Waiver

The pilot program for the waiver for individuals with Traumatic Brain Injury (TBI) began August 1, 2018. The waiver is starting as a pilot program in the Alliance catchment area. This HCBS waiver encompasses the needs of individuals with long-term care needs and more intensive rehabilitative needs. There are 49 slots approved for year one and 99 slots for year two.

5. State Waiver Authority to allow PIHPs and additional services – 1915(b) Waiver²⁷

Under this waiver authority, the state created prepaid inpatient health plans (PIHPs). The goal is for eligible recipients to be able to access all mental health, substance use disorder, and intellectual disabilities through a single local entity. The LME-MCOs operate as PIHPs for mental health, substance abuse and I/DD services. The state pays the PIHP a per member per month (PMPM) payment and the PIHP is responsible for making comprehensive provider networks available to all members including waiver participants, authorizing services, processing and paying claims, and conducting utilization and quality management functions. One of the goals of this capitated waiver was to enhance consumer involvement in planning and providing services through the proliferation of mental health recovery model concepts. As part of this waiver, the state has created 1915(b)(3) services from Managed Care savings. These supplemental services aimed at decreasing hospitalizations and helping individuals to remain or return to their homes and communities when preferred and appropriate. These savings offer an opportunity for the state to develop innovative solutions such as the TCLI initiative and CMS allowed components of supportive housing.

The 1915(b)(3) waiver services are in addition to, and not duplicative of, other services available under the State Plan, EPSDT, IDEA or Rehabilitation Act of 1973. These services are available statewide, are provided by the LME-MCOs and are included in the capitation rates certified by the state's actuary and from the savings that are generated by Managed Care. The following services are included but not a comprehensive list. Details on the services and the eligibility for them are below:

- **Personal Care/Individual Support:** Persons eligible for these services are adults with SPMI and LOCUS Level of II or greater, who are not covered under the NC Innovations Waiver.
- **Supported Employment:** Eligibility is SMI or I/DD and clinically appropriate for SE or ACT.
- **One-time transitional costs:** Consistent with NC Innovations Waiver, eligibility is SPMI transitioning from Adult Care Home, adult psychiatric institution or diverted from Adult Care Home.
- **Peer Supports:** Eligibility is adults over 18 with identified needs in life skills who have Axis I or II diagnosis and LOCUS Level I or ASAP I; or SPMI in adult care home, state psychiatric hospital or diverted from Adult Care Home. North Carolina has not included PSR in its approved State Plan. The state notes that Peer Supports will be removed from the next (b) waiver, as the services are now included in the state plan for persons with SMI or SUD challenges as of October 1, 2019.
- **Intensive Recovery Support:** Eligible persons are women with children who have been discharged from substance abuse treatment programs statewide.

6. Approved 1115 waiver²⁸

Under the 2018 approved waiver, the state will create regional pilots called "Healthy Opportunities."²⁹ These pilots will address Social Determinants of Health including housing, food, transportation, and interpersonal

²⁷ <https://medicaid.ncdhhs.gov/providers/programs-services/mental-health/behavioral-health-services>

²⁸ <https://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nc/nc-medicare-reform-pa2.pdf>

²⁹ <https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/healthy-opportunities-pilots>

violence. The program will pilot innovative care delivery models in 2-4 regions of the state and provide Medicaid enrollees with information, services, and benefits to improve health and lower costs through evidence-based interventions. Proposals were submitted by prospective “Lead Pilot Entities” in early 2020, and the state plans to announce awardees in spring of 2021.

The pilots are required to “address unmet needs that impact health and health care costs of North Carolinians through public-private regional pilots to identify, test, strengthen and sustain evidenced based interventions that can measurably improve health and reduce costs.”³⁰ The waiver amendment currently begins with housing as an example of a Pilot Evidenced Based Intervention.³¹ Examples include housing transition services, housing and tenancy sustaining services, medical-legal partnerships, and first month’s rent. The state will also offer “standard plans” with integrated physical health, behavioral health, and pharmacy services to most Medicaid enrollees, but “tailored plans” for persons with complex needs. The pilots have great potential to broadly address social Determinants of Health and gather the information needed to scale appropriate interventions.

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 North Carolina Medicaid State Plan, State Plan Amendments (SPAs) and relevant waivers. The Medicaid Crosswalk included an analysis of services provided by provider agencies that align with supportive housing services and are covered by North Carolina Medicaid. These are noted in Table 1 using the ✓ symbol.

In North Carolina, 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.

³⁰ Ibid, p 1 of the program description

³¹ Ibid, p. 7.

Table 1: Services covered by North Carolina Medical Assistance and additional State Funding Streams³²

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 ~ : State plan language doesn't cover service or ambiguity remains, barriers exist	TCLI³³ and TMS³⁴	CST	ACT³⁵	1915(c) Services Array
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	✓	✓	✓	✓

³² All of the services in this table are required to be provided by the LME-MCOs under the TCLI initiative.

³³ Some of these functions are performed by the provider network but many are also performed by the LME-MCOs.

³⁴ <https://www.ncdhhs.gov/divisions/mhddsas/documents/lme-mco-contracts>

³⁴ <https://files.nc.gov/ncdhhs/Transition%20Management%20Services-Final%20for%20Posting%206-3-16.pdf>

³⁵ NC Division of Medical Assistance Assertive Community Treatment (ACT) Program, <https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies/behavioral-health-clinical-coverage-policies>

B. State Plan Gaps

Some supportive housing services do not align with the current North Carolina 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 through CST or meet criteria for HIV Targeted Case Management (TCM) can *potentially* receive some supportive housing services from their service provider, as long as the service is medically necessary and is included in their treatment plan. Individuals with Serious Mental Illness who are residing in, or at risk of residing in, an Adult Care Home can receive a rich array of tenancy support services through the TCLI program. Additionally, individuals with I/DD or TBI are also eligible for some supportive housing services, as long as they meet institutional levels of care through the state's 1915(c) Innovations or TBI waivers.

Supportive housing services have proven beneficial for improving 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 North Carolina, supportive housing services are not currently covered through Medicaid unless the person meets an institutional level of care AND has a diagnosis described above (I/DD, HIV, OR SMI). Therefore, supportive housing services are NOT available for individuals with multiple unmanaged chronic health conditions who are homeless, unless they have at least one of these additional diagnoses. Navigating service systems to access these services can also be a challenge for people currently experiencing homelessness and many people may be eligible for services but not enrolled in services. This is the case despite the evidence promoting supportive housing as a valuable health benefit for a broader group of individuals than currently covered by the state's Medicaid plan.

People experiencing homelessness or with significant behavioral health needs are often challenged to address their physical health needs. Providers offered the need for easy to access integrated services models for people with co-occurring physical and behavioral health needs. People experiencing homelessness, commonly due to trauma and lack of connection to primary care over their lifespan, often exhibit physical health needs more common in persons much older than their chronological age. The service models developed to serve this population will need to address this issue.

2. Gaps in Services necessary for Quality Supportive Housing

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 covered in the TCLI program, the Community Support Team Service, and Assertive Community Treatment Services. In 2019, the state has updated the CST services definition to include components of quality supportive housing services.³⁶ Only individuals with SMI who are living in, or at risk of entering, adult care homes, or are being discharged from state hospitals to homelessness or unstable housing are currently eligible to receive services under the TCLI initiative. This package of services was created specifically to respond to the TCLI settlement aimed at reducing the number of individuals living in group facilities and institutions. State funding can cover outreach and engagement services under the TCLI program with leadership and support from the LME-MCOs. Service recipients must also have a qualifying and documented behavioral health diagnosis. Some of the services provided by the CST and the ACT teams, can support individuals in supportive housing. Outreach and engagement to persons who are eligible but not enrolled

³⁶ <https://files.nc.gov/ncdma/documents/files/8A-6.pdf>

in Medicaid could only be funded by state supportive resources and are commonly not offered. CSH is not aware of specific state or local designated resources to support this necessary activity.

Although the LME-MCOs can provide some behavioral health services to uninsured individuals, the state funding that covers those services is not an entitlement and the funding is not adequate. North Carolina did not expand Medicaid, and a June 2019 estimate indicates that over 600,000 people would gain coverage in a traditional Medicaid expansion in the state.³⁷

3. Gaps in Access to Waiver Services

The waiver for individuals with Intellectual and Developmental Disorders (I/DD) or Traumatic Brain Injury (TBI) offer an array of services to help persons remain in the community, but this waiver is only for those persons with I/DD. The services available would be helpful for persons without I/DD but who need a similar level of services to help them maintain housing in the community.

The waiver slots are capped at approximately 13,000 slots and the waiting list is over 12,000 persons statewide. The services offered through the LME-MCO under the TCLI Initiative are limited to those with a diagnosis of Serious Mental Illness which leaves out many individuals whose level of mental illness may not meet the SMI diagnosis or who may not have been diagnosed.

The 1115 waiver includes the Health Opportunities pilots that could include tenancy support services. States that have used pilot programs with the tenancy support services can gather information needed by the state on both scope and scale of services to build towards services that could be eligible to a broader population. NC's 1115 does not include work requirements or premium requirements, which are potential barriers to health care coverage and access.

North Carolina's 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 from their perspective 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 and other state sources is needed to bring this evidence-based practice to scale.

C. Provider Perceptions about Medicaid Coverage of Supportive Housing

The following section includes Community Mental Health providers, as historically only these agencies were funded or required to be licensed in order to offer these services, under North Carolina's current system. North Carolina does have supportive housing providers who are funded primarily through the HUD Continuum of Care (CoC) process and who are not currently, nor do they have, the capacity to bill Medicaid for their support services. While they bring valuable expertise around quality supportive housing, this provider group commonly needs both technical assistance and capital investment to transition to billing Medicaid for their services.

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 two Supportive Housing providers in Alliance's network to learn the breadth and depth of services that providers are currently offering to

³⁷ <https://www.conehealthfoundation.com/foundation/nc-medicaid-expansion-update/>

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. The interviews determined that all of the providers interviewed provided the following services: coordinating care; developing individualized housing support crisis plans; planning individualized services; giving referrals to other services and programs, together with monitoring and following-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.

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 Medicaid.

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

SERVICES	Providers Offer Service	Details of Provider Perception on Coverage
Care Coordination	All Offer	LME-MCOS offer under their contract. ACT and CST providers can bill under those services
Individual Counseling	Most Offer	LME-MCOs provider network offers this service or can be billed by as FFS if the person is not LME-MCO eligible under state plan
Medication Management	Some Offer	ACT and CST providers can bill under medication 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	
Pre-Tenancy: Assisting with rent subsidy application/certification and housing application processes	Most Offer	ACT and CST providers 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	LME-MCOs usually perform this service
Pre-Tenancy: Assisting in arranging for and supporting the details of move-in	Few Offer	Billable under TMS
Pre-Tenancy: Developing an individualized housing support crisis plan	All Offer	
Pre-Tenancy: Individualized Service Planning	All Offer	
Pre-Tenancy: Referrals to other services and programs	All Offer	
Tenancy-Sustaining Support: Providing early identification/intervention for behaviors that may jeopardize housing	All Offer	
Tenancy-Sustaining Support: Education/training on the role, rights and responsibilities of the tenant and landlord	Some Offer	

SERVICES	Providers Offer Service	Details of Provider Perception on Coverage
Tenancy-Sustaining Support: Coaching on developing/maintaining relationships with landlords/property managers	All Offer	
Tenancy-Sustaining Support: Assisting in resolving disputes with landlords and/or neighbors	Some Offer	
Tenancy-Sustaining Support: Advocacy/linkage with community resources to prevent eviction	Some Offer	
Tenancy-Sustaining Support: Assisting with the housing recertification process	All Offer	
Tenancy-Sustaining Support: Coordinating with tenant to review/update/modify housing support and crisis plan	All Offer	
Tenancy-Sustaining Support: Continuing training on being a good tenant and lease compliance	All Offer	
Peer Mentoring	Some Offer	
Transportation	All Offer	Non-emergency transportation (NEMT) is billable and accompaniment to medical appointments is billable under ACT and CST

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

3. Provider Identified Gaps in Covered Services and Reimbursement

The majority of services that are covered or have potential to be covered by North Carolina Medicaid must currently be provided by an LME-MCO. 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 Federally Qualified Health Centers or 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.

IV. CSH RECOMMENDATIONS

The State of North Carolina 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 North Carolina's leadership, providers, advocates, and consumers.

1. CAPITALIZE ON THE OPPORTUNITY OF THE STATE'S 1115 WAIVER

The state's 1115 waiver includes the possibility of pilot programs to use Medicaid resources to fund expanded supportive housing capacity. CSH has reviewed an early draft of the services definitions and the services align well with quality supportive housing. Of note, the waiver does not include long term rental subsidies. The LME-MCOs should be a key partner in a regional approach that ensures that:

- Long term housing resources are aligned with these opportunities to increase supportive housing capacity in communities. Engagement with the state Housing Finance Agency, local communities that manage HOME or Community Development Block grant funds, local Housing Authorities and the affordable housing developers, are all key partners that need to be a part of these efforts.
- Provider capacity activities are supported including a Medicaid Academy for supportive housing providers to develop billing capacity and a Supportive Housing Institute for the LME-MCOs to increase their understanding of quality supportive housing.
- The required 1115 evaluation includes analysis of the 1115 waiver services and includes study of the impact of supportive housing on population health, change in health equity for communities, healthcare outcomes at the individual and community level AND health care costs.

2. DEVELOP STATEWIDE STANDARDS AND TRAINING FOR QUALITY SUPPORTIVE HOUSING

North Carolina, through its Olmstead settlement agreement and its Continuums of Care, has significant supportive housing capacity. In our interviews, however, the quality of the supportive housing was commonly noted as highly variable. In order to ensure quality supportive housing through active and new resources, CSH recommends that the state develop and implement quality standards in supportive housing to ensure that these resources are being implemented in an evidenced-based and effective manner. The development of these standards should be led by the state, but include stakeholders statewide, including current, former and prospective supportive housing tenants, supportive housing providers, health care delivery system leaders, and state officials.

To implement standards, the state should lead training activities around the standards and the monitoring process that will be put in place to ensure accountability to the standards.

Training and provider capacity building should be supported for all parties involved including LME-MCOs, MCOs and health and behavioral health organizations, and supportive housing and homeless services providers. The health care entities will need to learn more best practices in supportive housing development, operations, and outcomes. Supportive housing providers will need

Providers prioritize what the state requires. Standards and training to implement those standards would improve the focus on sustaining housing tenancy for service models such as ACT and CST that already serve people experiencing homelessness or housing instability.

to learn about how to contract with the health care sector to create sustainable quality models for their programs. Job role specific training is recommended for persons who develop, manage, supervise and deliver supportive housing services. 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. Supportive housing care coordination involves all crisis service systems, 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.

The state will also need to develop a mechanism to ensure accountability and adherence to standards. This role commonly would live with the Managed Care Organizations (MCOs) as part of their credentialing process. However, MCOs commonly have limited expertise regarding Supportive Housing and services to people experiencing homelessness, so state expectations and leadership will be crucial to roll out this effort effectively.

3. CREATE A SUPPORTIVE HOUSING SERVICES BENEFIT IN NORTH CAROLINA'S STATE PLAN THROUGH A 1915i STATE PLAN AMENDMENT.

Supportive housing services should be explicitly included in the North Carolina State Plan to align with CMS guidelines of pre-tenancy and tenancy-sustaining services included in its Informational Bulletin released on June 26, 2015. The benefit should focus on populations not covered under the TCLI initiative. CMS is currently supporting states to develop and request 1915i State Plan Amendments or SPAs to include tenancy support services as part of their Home and Community Based services package. The 1915i SPA requires the state to develop needs-based criteria and allows the state to cover individuals who do not yet meet institutional levels of care. Minnesota's 1915i request includes persons who are experiencing chronic homelessness and has been approved by CMS.³⁸ The state should consider a per diem or per member per month (PMPM) financing system for these services to ensure maximum flexibility for the provider network. CSH is available for consultation to further explore these options with the state.

In addition, creating these services in the State Plan will enable the state to use the state-funded only services for those individuals who remain ineligible for Medicaid and/or for services that cannot be covered under Medicaid.

Under any authority, an important consideration will be to ensure that providers who currently deliver high quality supportive housing are able 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.

4. MAP HOW HOME AND COMMUNITY BASED WAIVER SERVICES (HCBS) ARE ACCESSED IN NORTH CAROLINA, AND WHAT BARRIERS REMAIN TO ACCESSING SERVICES FOR VULNERABLE POPULATIONS

Building on their current Home and Community Based Services (HCBS) system, North Carolina should also map out the processes required for accessing these various waivers and services. The current four waivers target people who meet institutional levels of care. CSH's reviews of HCBS in multiple states have found that they are

³⁸ <https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MN/MN-18-0008.pdf>

multi-step processes that are difficult to navigate for persons with disabilities who are also experiencing homelessness. Their service providers and advocates for these persons also find them challenging to navigate due to multiple appointments and required access to specialized medical personnel that are not reimbursed for this assessment process. North Carolina can avoid these common pitfalls by mapping the process for access and ensuring that the resources are available in communities to facilitate access to medically necessary services.

5. EVALUATE COST SAVINGS AND REDIRECT THOSE SHARED 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 statewide analysis of Medicaid claims data for individuals who are homeless and frequent users of high-cost emergency services offers the potential for North Carolina to understand more concretely the cost savings potential supportive housing services could create. Alliance has done an internal analysis to begin to develop realistic cost models for serving this population. Once realized, federal cost savings should be reinvested back into supportive housing services. State and managed care cost savings can be redirected back into both 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. CSH believes that this recommendation is in line with the goals of DHHS.

CONCLUSION

CSH believes that with the implementation of the 1115 waiver, North Carolina is at a crucial juncture in the transformation of their health care system to better address the health care and social needs of their most vulnerable residents. During their transition to a managed care delivery structure and the development of Tailored Plans to address the needs of persons with significant behavioral health disorders, the system's solid understanding of the impact of social determinants of health are all necessary to reach their health care delivery system goals. Those goals include:

- ✓ Expand access to supportive housing. Target supportive housing resources to those most in need in a community, particularly those experiencing chronic homelessness and multiple complex care needs.
- ✓ End homelessness in the state.
- ✓ Ensure compliance with the Olmstead settlement, both in the letter and the spirit of the law.

The recommendations in this report are in line with the goals of the DHHS and local stakeholders who know supportive housing is the solution for a small subset of Medicaid beneficiaries. This report offers a thorough analysis that confirms the need for statewide standards for supportive housing and the need for expansion of tenancy obtaining and tenancy sustaining services for a subset of Medicaid beneficiaries with complex care needs and limited recovery capital. Alliance Health'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 Carolina residents who are most in need.