2026 ILLINOIS MEDICAID SUPPORTIVE HOUSING SERVICES CROSSWALK

HETAC

The Homelessness Education and Training Technical Assistance Center

A program of SHPA

Building the field. Opening the door.

ABOUT SHPA THE HOMELESSNESS EDUCATION AND TECHNICAL ASSISTANCE CENTER

The Supportive Housing Provider Association (SHPA) is a statewide membership association of non-profit providers of supportive housing (affordable housing plus services for individuals and families who have been homeless and/or have special needs). SHPA knits its members together into a strong state and federal advocacy voice for supportive housing resources and policies. SHPA staff support several efforts, including:

- Provide advocacy, policy, and advocacy training for members and supportive housing staff;
- Connect supportive housing staff and residents to federal and statewide advocacy campaigns;
- Identify, achieve and report on quality supportive housing by connecting them with training and technical assistance; and
- Connect members with each other and national leaders at membership meetings.

To learn more, visit the HETAC – Supportive Housing Providers Association website.

ABOUT CORPORATION FOR SUPPORTIVE HOUSING (CSH)

CSH

CSH is the national champion for supportive housing, demonstrating its potential to improve the lives of highly impacted individuals and families by helping communities create over 335,000 homes with supportive services for people who need them. CSH funding, expertise, and advocacy have provided nearly $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 systems to 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. CSH advances solutions that use housing as a platform for services to improve the lives of highly impacted people, maximize public resources and build healthy communities. Visit us at www.csh.org.

ACKNOWLEDGEMENTS

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This report would not have been possible without input from state staff and staff from the healthcare, housing, and homelessness sectors who shared information about the day-to-day operations of their programs across Illinois.

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INTRODUCTION

In recent years, both state and federal partners have identified new tools and opportunities to link housing and services in ways that are more effective and efficient for those who need assistance. These services commonly operate beyond the traditional office or hospital-based healthcare system and are more community-focused. These health funding opportunities build upon the advocacy, collaboration, and effective programs created by champions in the housing industry, especially partners focused on improving health outcomes for those experiencing homelessness and housing instability. On January 7, 2021, the Centers for Medicare and Medicaid Services (CMS) sent a letter to State Health Officials (SHO) outlining opportunities under Medicaid to better address social determinants of health (SDOH) with the intention of supporting states in designing programs, benefits, and services that can more effectively improve population health, reduce disability, and lower overall health care costs.[1] Recognizing the positive impacts of supportive housing for a subset of Medicaid beneficiaries who need stable housing and better access to healthcare, the state of Illinois sees the potential of supportive housing to improve population health outcomes, and address homelessness and housing instability in its communities. This potential has been translated into a strong statewide commitment to supportive housing.

The state of Illinois recognizes the opportunity to further integrate supportive housing services into Medicaid and grow their supportive housing capacity. The Supportive Housing Providers Association (SHPA) contracted with CSH to complete this Medicaid Supportive Housing Services Crosswalk to determine the degree to which the services in Illinois's Medicaid program, also known as HealthChoice Illinois, currently aligns with supportive housing services in policy and practice and where gaps would need to be addressed to ensure that the most impacted beneficiaries can live in their own homes and communities with stability and autonomy. CSH's crosswalks help educate the homelessness and housing sector around the Medicaid programs in their state, including populations covered, services offered and opportunities for ensuring people can access quality health care services. CSH has analyzed more than a dozen state Medicaid plans, comparing services offered and populations covered with the services provided in quality supportive housing. CSH has also assisted multiple states in the process of developing and/or implementing new Medicaid benefits for supportive housing services, referred to throughout this document as pre-tenancy and tenancy support services. Illinois' federally approved Medicaid 1115 waiver calls these services "Housing Supports" and includes additional services.

[1] Social Determinants of Health (SDOH) State Health Official (SHO) Letter (medicaid.gov)

The CSH Illinois Medicaid Crosswalk ultimately aims to spotlight how Medicaid can make healthcare and housing more accessible for highly impacted Medicaid beneficiaries. Figure 1 below highlights what this ideal journey could look like for Illinois residents, when services and housing are integrated at the system and program level.

This Crosswalk is organized into four parts:

1) Background on Supportive Housing
2) Overview of Medicaid in Illinois
3) Crosswalk Findings
4) CSH Recommendations

PART ONE: BACKGROUND ON SUPPORTIVE HOUSING

Supportive Housing

Supportive housing combines affordable housing with intensive tenancy support services and whole person care coordination to help people who face the most complex challenges live with stability, autonomy, and dignity. People who benefit from supportive housing include people experiencing chronic homelessness[2] (extended periods of homelessness and one or more disabling conditions), people who live in public institutions, nursing homes and licensed residential settings but want to transition back into their communities, people returning to communities from carceral settings, people who cycle between homelessness and these settings and families with complex needs.

As a federally recognized evidence-based practice,[3] research demonstrates that supportive housing provides stability, improves health outcomes, and reduces public system costs. Supportive housing is not affordable housing with light touch onsite resident services. It is a specific intervention that is driven by participant's choice of setting and in service delivery. Supportive housing provides assertive, specialized tenancy support services with low staff-to-client ratios of 1:10 or 1:15 and each tenant has an individualized services plan.

The **housing** in supportive housing is ideally, deeply affordable. In deeply affordable housing, tenants pay thirty percent of their income toward rent and utilities. Subsidies pay the remaining rent amount. Supportive housing is independent like any other rental housing and requires a lease with full tenancy rights and responsibilities. Supportive housing tenants have the same lease as any other tenant of a property. This housing is a platform that enables tenants to access health-related and other supportive services, helping them improve their lives. 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). Services such as Home Remediation and Home Accessibility services and resources align easily with Supportive Housing since the goal of all these efforts is a thriving life in the community. Service providers working in supportive housing connect tenants to primary and behavioral healthcare and other community resources. Services such as benefits navigation, counseling, peer support, independent living skills, supported employment, end-of-life planning, childcare, and crisis support are also provided to residents by supportive housing service providers and/or their community partners. Supportive Housing operates as a Whole Person Care Coordination model. Research has shown that supportive housing is one of the most effective ways to decrease avoidable over-spending on emergency health services and reduce the criminalization and unnecessary institutionalization of people in need of accessible housing and healthcare. [4]

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[2] HUD's Definition of Homelessness: Resources and Guidance - HUD Exchange

[3] SAMHSA Supportive Housing Evidence Based Toolkit. https://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4509

[4] Permanent Supportive Housing: Evaluating the Evidence for Improving Health Outcomes Among People Experiencing Chronic Homelessness | The National Academies Press and more recently What We Learned from the Evaluation | Urban Institute

Financing supportive housing requires "three legs of a stool," 1) capital funds to build apartment buildings, 2) rental assistance to reduce the rent burden for tenants with extremely low incomes, and 3) supportive services to assist tenants in accessing housing, social services and healthcare so that they can thrive in their communities. Most states and localities do not have the resources to take this intervention to scale. A lack of sustainable services funding often delays the creation of new supportive housing. Funding services has historically come in the form of grants and contracts attempting to address long-term needs. Instead of using these funds to create more housing, communities use a significant portion of these limited resources to pay for the tenancy supports in supportive housing that Medicaid could instead cover.

The Need for Supportive Housing in Illinois

The state's "Home Illinois: Illinois' Plan to Prevent and End Homelessness" outlines the significant investment the state has made in affordable and supportive housing statewide.[5] But despite significant public sector investments in institutions, long-term care facilities, jails, shelters, residential treatment facilities, and hospitals, individuals experiencing homelessness frequently do not receive the care they need and therefore face challenges in improving their health and well-being. Instead, they experience expensive and often preventable institutionalization, lack of access to primary care, and lack of integrated services addressing their complex care needs. While these residents represent a small percentage of the total state population, the State makes disproportionately large investments in the systems most accessible to them without addressing their needs or those of their communities.

In looking at the broader affordable housing needs in the state, the National Low Income Housing Coalition 2024 Out of Reach Illinois Report, a household at 30% of the area median income (AMI) can afford rent of $790 per month and 447,330 renter households are below 30% AMI.[6] To rent a one-bedroom apartment at fair market value, a household would need to pay $1,289.[7] For people who are disabled and on Supplemental Security Income, recipients in Illinois receive $967 per month, making even 30% AMI units out of reach. They are unable to afford the rent in Illinois without a subsidy. These beneficiaries experience housing instability, homelessness, and/or are cycling through multiple social service systems, acute care settings, and institutions.

The above report also notes that Illinois needs over 289,000 rental homes to be available and affordable to "extremely low-income renters" with an average household income of $32,020.[8] According to the 2024 Illinois Office to Prevent and End Homelessness (OPEH) Home Illinois: Illinois' Plan to Prevent and End Homelessness Annual Report, Illinois needed 22,153 permanent housing units to reach functional

[5] IDHS: Home Illinois Plan
[6] Out of Reach: Illinois | National Low Income Housing Coalition
[7] Out of Reach: Illinois | National Low Income Housing Coalition
[8] Illinois | National Low Income Housing Coalition

zero by the end of 2025.[9] This modeling reflected a gap of 10,972 units that need to be created to meet that goal. While the HUD homeless definition excludes people who are doubled up and in institutions, OPEH modeled housing needs for residents returning from incarceration and students living doubled up were studied to understand how many shelter and housing units would be needed to reach functional zero for these populations. For returning citizens, 492 supportive housing units and 2,472 affordable housing units are needed. In the education system, 999 supportive housing units and 25,981 affordable housing units are needed.[10]

In the 2024 Health Outcomes Disparities report, produced by the Illinois Department of Human Services, state officials identified access to affordable housing as the first of several factors driving poor health outcomes in the state, again highlighting and confirming the need for additional supportive housing in the state.[11] In 2024, according to the HUD 2024 Continuum of Care Homeless Assistance Programs Report, Illinois identified 15,817 households experiencing unstable housing; of this total, 75% (11,935) lived in emergency housing locations. During the same year, 25,832 individuals experiencing homelessness resided in Illinois, of which the majority comprised households with at least one child under 18 years old. The majority of those experiencing unstable housing in Illinois were Hispanic/Latine (42%), women (40%), Black (26%), and comprised of families with at least one adult and one child under 18 years old (28%).[12] 2024 data include the significant increase in new arrivals from the southern border.

Although Illinois does not currently match data between the Medicaid and homelessness systems, we can make plausible assumptions about the connection between homelessness and Medicaid enrollment based on other research and income and the lack of supportive and affordable housing resources in Illinois, especially after Medicaid expansion under the Affordable Care Act (ACA). Before the federal government approved Medicaid enrollment expansion efforts in 2013, over half (57%) of unhoused people served by HRSA-funded Health Care for the Homeless (HCH) programs nationally were uninsured. However, by 2023, 62% of unhoused people in expansion states were covered through Medicaid.[13] With this context in mind, we can better understand Illinois' enrollment trends in recent years. In 2024, Illinois provided Medicaid coverage to 3,462,873 enrollees – a 519,094 reduction in total enrollees from FY2023, but similar to enrollment levels recorded in FY2020 and FY2021. Of those enrolled in Medicaid during FY2024, 772,233 adults newly eligible under the Affordable Care Act expansion efforts – most likely including many new adults experiencing homelessness – had access to comprehensive Medicaid benefits.

A subset of Medicaid beneficiaries in Illinois have critical, unmet housing needs and their health worsens as the housing needs are not met. Many Illinois residents have co-occurring physical health and behavioral health conditions, including severe mental illness, substance use disorders, functional impairments, and other disabilities. CSH's 2026 Supportive Housing Needs Assessment estimates that the

[9] Home Illinois: Illinois' Plan to Prevent and End Homelessness - Annual Report 2024-2026
[10] Home Illinois: Illinois' Plan to Prevent and End Homelessness - Annual Report 2024-2026
[11] Health and Human Services Task Force Health Outcomes Disparities Report 2024, pg. 4
[12] HUD Exchange, CoC_PopSub_State_IL_2024.pdf
[13] National Health Care for the Homeless Council, Homelessness-and-Medicaid-Whats-the-Connection_.pdf

state needs an additional 40,675 supportive housing units including 38,363 units for individuals and 2,312 units for families across all populations.

Housing and Service Programs in Illinois

Several local and State initiatives are underway to make a dent in the supportive housing need in Illinois. The following are a few key examples:

- Illinois' Statewide Referral Network and Section 811 Project-Based Rental Assistance Program (PRA) provides new housing and supportive services for eligible participants statewide. Individuals need to be Medicaid eligible, service connected, and able to meet additional age, income, and prioritization criteria. Since the program's inception, the state has distributed over $18M to create more than 900 units of housing for those in need. [14]
- Illinois has several Medicaid "home and community-based" waiver programs (HCBS) for adults in Illinois. Most of these programs focus on caring for adults who are aging or with physical and developmental disabilities.[15] Although the exact number of individuals receiving HCBS services in 2025 is not available at the time of this analysis, there are several sources that have relatively recent data. The Kaiser Family Foundation reported in 2024 that 15,095 individuals with intellectual and developmental disabilities were on the I/DD waiver waitlist in Illinois, with the IDD waiver being the only one with a waitlist.[16] Another data sources is dashboard created by ATI Advisory that includes Medicaid beneficiaries' use of home- and community-based services (HCBS) on a state and county-by-county basis. Based on 2022 data, there are 310,625 LTSS users in Illinois. Of these, 240,027 are HCBS LTSS users and 86,786 are Institutional LTSS users.[17] The counties with the highest number of HCBS LTSS users are Cook, DuPage, Will, Lake, and St. Claire.
- Illinois has grant based funding for supportive housing services, through the Illinois Department of Human Services (IDHS) that provides services in housing programs for eligible formerly homeless individuals and families. In FY25, 73 programs received this funding. After initial intake and assessment processes, program participants can receive support for a variety of services, including case management, transportation, childcare, health and dental services, and additional services.[18]

[14] IDHS: Supportive Housing
[15] Supportive Living Program | HFS
[16] Number of People Waiting for Medicaid Home Care (HCBS), by Target Population and Whether States Screen for Eligibility | KFF
[17] ATI Advisory LTSS Users by State and County
[18] IDHS: Supportive Housing

PART TWO: OVERVIEW OF MEDICAID IN ILLINOIS

The Medicaid Program Nationally

Medicaid is public health insurance that pays for essential medical and medically related services for people with low income. Statutorily, Medicaid insurance cannot pay for room and board or rental assistance. Medicaid's ability to reimburse providers for services starts with a determination as to whether an individual is Medicaid eligible and if so, if the person is enrolled in the Medicaid program to receive health care coverage AND if the agency is enrolled in the state Medicaid program to bill for those services.

At the federal level, CMS oversees all state Medicaid plans. A Medicaid "State Plan" is the contract between a state and the federal government. It defines the services, eligible populations, and payment rates that are part of the state's Medicaid program. All state plans cover certain "essential health benefits" as determined by federal statute. States and CMS can also agree to cover additional benefits designated as 'optional' in federal statute.[19] Illinois expanded Medicaid to cover populations that were solely low income in 2014. The state also has a "trigger law" that would end expansion coverage or require taking steps to mitigate increases in state costs if federal funding for expansion is reduced.[20] States can make changes to their Medicaid State Plan by applying to CMS for a state plan amendment (SPA) or to waive certain provisions of the Social Security Act that govern Medicaid regulations (a Waiver). Medicaid authorities are commonly known by their federal statute section number. Examples of authorities that can help states address housing as a Medicaid-covered service include:

- 1115 Medicaid Waivers allow for state research and demonstration programs to pilot innovative services, serve new populations, or test payment structures.
- 1915(c) Waivers and 1915(i) SPAs: Among other benefits, States can use these authorities to provide Home and Community Based Services (HCBS) for specific populations (e.g., seniors with functional impairments, adults with severe physical disabilities, individuals with severe or persistent mental illness, individuals with developmental disabilities, children with special health care needs and people living with traumatic brain injuries). These services are intended to help beneficiaries remain in their own homes and communities for as long as possible, rather than requiring that they move into institutions to receive the level of care they need.[21]

States can reimburse providers directly for services in a Fee for Service (FFS) structure or they can contract with managed care organizations (MCOs) to establish a provider network and manage payments to those providers. States contract with MCOs primarily on a per member per month (PMPM) basis. This shifts the financial risk onto the MCOs. While MCOs may have greater flexibility than state governments to contract for provider services, they may also occasionally need to limit the services they cover to stay

[19] For more detail on mandatory and optional Medicaid benefits - https://www.medicaid.gov/medicaid/benefits/mandatory-optional-medicaid-benefits/index.html
[20] Status of State Medicaid Expansion Decisions | KFF
[21] https://www.kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/

within their budget. States and MCOs establish agency licensing and credentialing requirements and staff qualifications that determine which providers can receive Medicaid reimbursement.

Indian Health Service (IHS), another agency within the federal Department of Health and Human Services, is responsible for providing federal health services to American Indians and Alaska Natives. The federal government provides 100% payment for services provided to American Indian and Alaska Natives receiving healthcare in IHS facilities, which include Tribal Contract or Compact Health Centers that deliver outpatient healthcare programs and Urban Indian Health Centers, which are designated Federally Qualified Health Centers that provide comprehensive primary care and related services. These facilities are owned or leased by Urban Indian organizations and receive grant and contract funding through Title V of the Indian Health Care Improvement Act. In April 2024, Illinois legislature formally recognized the Prairie Band Potawatomi as a tribal nation, transferring over former-trust land to the nation in the process.[22] As of the time of this report, Illinois does not have any other federally recognized tribal nations or tribes. For Indian Health Service (IHS) clinical resources, there is one Health Center in Illinois (Chicago), and zero hospitals, dental clinics, or behavioral health clinics.[23]

Medicaid in Illinois

Illinois offers Medicaid benefits primarily through Managed Care Organizations (MCOs) including those with Medicaid and Medicare enrollees who are covered by Dual Eligible Special Needs Plans or D-SNPs[24]. Illinois first began offering managed care coverage to select groups of eligible Medicaid recipients (mainly, low-income children and families, pregnant women, and Indigenous Americans in select counties) in 1976[25]. Building on the experiences of previous managed care offerings – including the 2006 Illinois Health Connect program for acute, primary, and specialty care case management in a medical home, and the mandatory 2011 Integrated Care Program for older adults and those with disabilities - Illinois revised its managed care offerings several years later. The current statewide HealthChoice Illinois managed care program started in 2018[26] although there have been earlier iterations of managed care in Illinois, including Accountable Care Entities and Care Coordination [27]. With HealthChoice Illinois, the following eligible recipients include:

- Families and children
- Adults eligible for Medicaid benefits under the Affordable Care Act expansion criteria
- Seniors and adults with disabilities, commonly called the Aged, Blind, and Disabled population.
- "Dually-eligible" Medicaid-Medicare recipients receiving long-term supports and services (LTSS) in the community
- Children with special needs, including former and current "Youth In Care" or foster care youth

[22] Illinois is now home to a federally-recognized tribal nation | NPR Illinois
[23] Indian Health Service Find Health Care
[24] Medicare-Medicaid Alignment Initiative | HFS
[25] illinois-mcp.pdf
[26] IDHS: Information provided by HFS in a recent notice re: credentialing
[27] Accountable Care Entity (ACEs) and Care Coordination Entities (CCEs)

As of 2026, there are three plan types within the HealthChoice Illinois program: a HealthChoice Managed Care Plan for those receiving *only* Medicaid benefits, a HealthChoice YouthCare plan serving current and former youth served by the Illinois Department of Children and Family Services, and Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP), which is a type of Medicare Advantage plan that provides both Medicare and Medicaid benefits through a single managed care plan plans for Medicaid-Medicare dually-eligible participants. Currently, five organizations offer HealthChoice Managed Care plans, four offer MMAI plans, and one plan (Centene) provides care under the HealthChoice Youth Care plan[28] Five insurance companies – Aetna Better Health, Blue Cross Community Health Plans, Meridian, and Molina HealthCare operate statewide, with CountyCare serving Cook County only. Based on publicly available data from the [29], Figure 2 summarizes plans providing coverage under current state programs:

Figure 2.

Program	Plan	Plan Notes
Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP[30]	• Aetna Medicare FIDE • Humana Dual Fully Integrated • Wellcare Meridian Dual Align • Molina Medicare Complete Care Plus	• Offers primary care, specialty care, acute and post-acute care services, home health, and medical equipment
HealthChoice Illinois[31]	• Aetna Better Health • Blue Cross Community Health Plans • Meridian • Molina HealthCare • CountyCare (Cook County residents)	• All plans except CountyCare serve eligible members statewide
YouthCare	• Centene	• Specialized health plan for youth in care and former youth in care with DCFS

[28] Illinois' Managed Care Programs | HFS
[29] 04 30 2021 IL MMAI Expansion By County And Plan Final
[30] Fully Integrated Dual Eligible Special Needs Plans in Illinois
[31] IL2026 Managed Care Map (January 2026)

PART THREE: CROSSWALK FINDINGS AND ANALYSIS

Materials Reviewed for the Crosswalk

This Crosswalk concentrates on Illinois Medicaid services that address the healthcare needs of beneficiaries with functional impairments who are likely to be impacted by housing instability, homelessness, and/or unnecessary institutionalization. The Crosswalk considers various sources of information in determining the degree to which HFS covers supportive housing services in policy and practice. Sources include: 1) A review of publicly available, relevant documents, and 2) Interviews with providers who serve these populations.

The following is a brief description of which Medicaid authorities above do or do not align with supportive housing services.

For the document review, CSH reviewed the following:[32]

1. 1915c IL Persons with Brain Injury Waiver
    - CSH found very limited alignment between HFS's 1915(c) IL Persons with Brain Injury Waiver and quality supportive housing services.
2. 1915c Waiver for Individuals with intellectual and developmental disabilities (I/DD).
    - CSH found very limited alignment between the state's 1915c Waiver for individuals with intellectual and developmental disabilities and quality supportive housing services.
3. 1915c Waiver for Persons with Disabilities
    - CSH found very limited alignment between the state's 1915c Waiver for Persons with Disabilities and quality supportive housing services.
4. 1915c Home and Community-Based Waiver for Elderly Persons
    - CSH found very limited alignment between the state's 1915c Home and Community-Based Waiver for Elderly Persons and quality supportive housing services.
5. Persons with HIV/AIDS
    - CSH found very limited alignment between the state's program for those living with HIV/AIDS and quality supportive housing services.
6. Supported Living Program
    - CSH found targeted alignment between the state's Supported Living Program and quality supportive housing services.
7. 1115 Healthcare Transformation Waiver
    - CSH found promising alignment between Illinois's newest 1115 waiver, the Healthcare Transformation Waiver, and quality supportive housing services.
8. 1915i State Plan Amendment for Substance Use Disorder (SUD) Services
    - CSH similarly found very limited alignment between the state's program for those living with HIV/AIDS and quality supportive housing services.

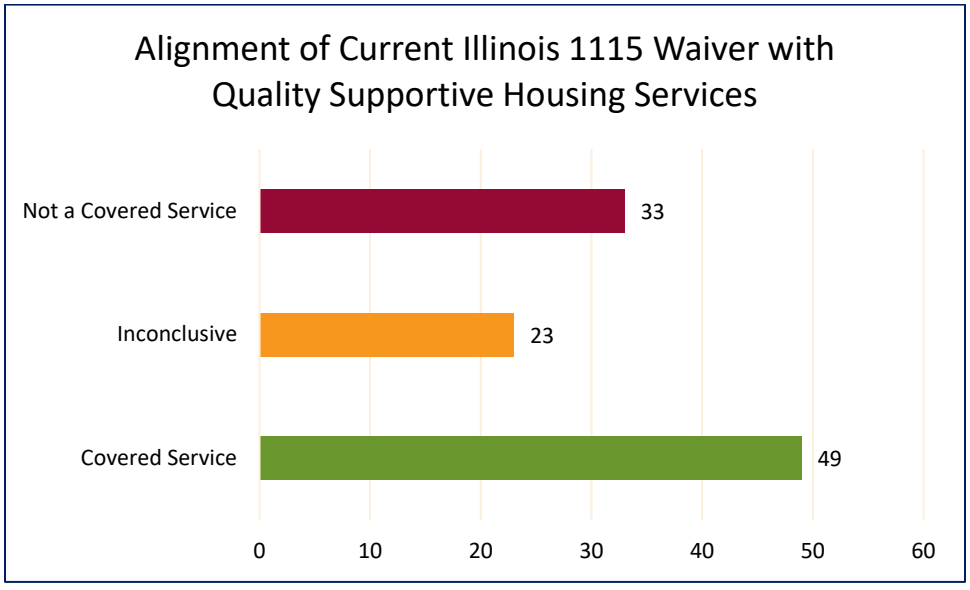
[32] Home and Community Based Services Waiver Programs | HFS

9. Community-Based Behavioral Health Services (Psychosocial Rehabilitation)
    - As with other state programs, CSH similarly found very limited alignment between the state's community-based behavioral health services and quality supportive housing services.
10. Assertive Community Treatment (ACT) Programs
    - As with other state programs, CSH similarly found very limited alignment between the state's ACT programs and quality supportive housing services.

CSH found that most of the services listed above, with the exceptions of the new 1115 waiver and ACT programs do not cover housing services, nor could housing services be considered a part of these Medicaid authorities.

CSH was not able to access the full Illinois State Medicaid Plan, so the information above is focused on information from current Medicaid waivers and state plan amendments and state web sites. When looking at the services offered across all Medicaid waiver programs (including the latest 1115 waiver program), Figure 3 below is a summary of how well the current 1115 waiver in Illinois aligns with quality supportive housing services. Of the services available in the 1115 waiver, 49 are clearly defined in the 1115 program's service description. 23 services may be provided in the 1115 program, but it is not clear based on the current application and implementation plan language. When comparing the services offered in the 1115 waiver program against the list of services shared across all Illinois waiver programs (not including the Medicaid state plan), several service gaps remain. The table below describes the comparison further.

Figure 3



Services critical to quality supportive housing yet not covered by all other waiver programs, include services such as:

- Housing-focused care coordination with other community providers (direct communication with other providers regarding client well-being) (hospital/jail discharge planning, housing liaison for tenant's care providers)
- Assistance with housing recertification process
- Coordination with tenant to review/update/modify the housing support plan and eviction prevention plan
- Eviction prevention planning & coordination

Assertive Community Treatment is the next most aligned service with quality supportive housing, but of note is that most services are "Possible" under ACT but not called out or required. Services that could be delivered under ACT's comprehensive model include outreach, tenancy sustaining services, and life skills. These services are not specifically mentioned under ACT regulations that we reviewed but are part of a comprehensive care coordination model such as ACT. CSH has found in other states that for ACT teams to deliver these services, specific state expectations, training and support and connections to independent housing options are necessary.

Findings from Illinois Providers

During CSH provider interviews and engagements, we were able to identify common themes and takeaways. The purpose of the provider interviews was to inform where alignments and gaps exist between supportive housing services and Medicaid in practice. Also contributing to the below analysis is activities from the last two years, which included interviewing provider interviews, facilitating informational webinars spanning 2023-2025, providing TA to support providers in understanding their total cost of care, supporting a HFS listening session, and offering a webinar focused on lessons learned from supportive housing providers that previously transitioned from grant-based funding to starting Medicaid billing.

The interview participants ranged in location and service provision. Some providers offer supportive services to the larger community, while others provide services and housing specific to their program participants and tenants. The providers served west central rural Illinois, the Chicagoland and Cook County region, and northern Illinois. The providers offered supportive services including homeless system case management, workforce development, mental health services, crisis management, tenancy skill building, parenting supports, housing counseling, and peer supports such as Certified Recovery Support Specialist (CRSS). Their populations served ranged from young moms, people with intellectual and developmental disabilities, people with behavioral health needs, victims of domestic and partner violence, as well as the community at large. The interviews included a series of questions about the funding and operations of their programs, their understanding of Medicaid reimbursement for supportive housing services, and their perceptions of Medicaid alignment with supportive housing services. CSH also

sought to understand the array of services that supportive housing service providers are currently offering to tenants, regardless of the funding source.

Across different types of engagements, providers shared:

- The Medicaid rate does not adequately capture the total cost of providing services. Billing Medicaid has a large administrative burden, and current rates do not capture the total cost of care.
- It is difficult for smaller providers to take on the burden and risk of Medicaid billing. The startup costs, administrative burden, and capacity that Medicaid billers need is significant enough that it is likely some providers will determine it doesn't make sense for them to become direct Medicaid billers. In addition to the administrative burdens, rates that don't fully cover the cost of providing services and requires providers to leverage other resources and operate at a much larger scale to increase efficiency. This presents a unique challenge for rural providers, who will have scaling limitations in their area.
- There is a misalignment currently between what Medicaid Rules 132 and 140 stipulate as Targeted Case Management (TCM) services and how pre-tenancy and tenancy sustaining services are defined and provided in supportive housing. "It is like trying to fit a square peg in a round hole." The rules listed above require that only a limited number of behavioral health specialty providers can offer TCM services. These agencies are seldom the agencies who develop and operate supportive housing or other homeless services.
- Billing Medicaid will not solely sustain supportive services in a supportive housing program. Housing organizations need to rely on utilizing multiple funding streams to sustain service delivery. Many organizations do not have the sophisticated financial management systems needed to braid funding for a single program in this manner. Moreover, funding guidance from each funding stream does not cover what funds can and cannot be braided in a compliant manner, so agencies need a certain amount of risk tolerance to braid funds.
- There is a need for capacity building for service providers. The skillset of billing can limit an organization's ability to utilize Medicaid. Organizations need assistance with technology infrastructure, billing expertise, and MCO contracting. Each activity listed explains how organizations will need to invest significant resources if they intend to start billing Medicaid. Providers that have already transitioned to become Medicaid billers share that the first 6+ months are challenging due to the significant learning curve.
- Connecting people who are potentially eligible for housing is time-consuming and is often underestimated. It requires outreach support and follow-through that services providers do not always have the capacity for.
- If these services aren't consistently and widely available to providers for supportive housing tenants with long term, complex support needs, it is unlikely this new source of funding will have any impact on new housing creation. Medicaid members across Illinois need new housing resources created and made available to them, and we desperately need to figure out how to create more affordable, subsidized housing.
- Supportive housing providers that currently bill Medicaid report they struggle trying to get services for new tenants in their supportive housing buildings, because so many new tenants

move in without having active Medicaid. As a system, there needs to be some more thought and resources put into making sure people who are homeless and connected to CoCs and coordinated entry systems are also being connected to Medicaid as quickly as possible. Most CoCs don't gather this information, and if they do its self-report. Only providers that already bill Medicaid would have access to the State systems to verify active Medicaid status. This gap creates delays and challenges.

Summary and Analysis

The state of Illinois has a unique opportunity with its current 1115 Health Related Social Needs (HRSN) waiver to align supportive housing services with the services required for quality supportive housing. Illinois has also invested in Assertive Community Treatment services for a small segment of the population with serious mental illness and those services could also more explicitly include Housing Support services with state direction and support. While the state has a robust HCBS system and services, relatively few of those programs offer many of the services required for quality supportive housing. However, the waiver cannot offer long-term rental assistance, and aligning housing with these services is a critical system of activity needed. Currently, Illinois residents in need of supportive housing have a variety of access points including Coordinated Entry, the SRN and 811 waitlist system, and HOPWA. There are additional supportive housing resources in the Division of Behavioral Health and Recovery system for eligible individuals identified via Williams and Colbert Consent Decrees, Front Door Diversion, and supportive housing funded by Substance Use Prevention and Recovery (SUPR). Integrating the new 1115 services into these systems and access points will ensure these services lead to an increase in supportive housing capacity needed by state residents.

Illinois' many HCBS programs are varied, and most are 1915(c) waivers, requiring a person to meet a nursing home level of care. This eligibility threshold cannot be accessed by most people experiencing homelessness and housing instability and those waivers cover few of the services required for quality supportive housing, including housing location and navigation supports which are critical to ensuring people with complex support needs are able to access housing. If the state wishes to ensure housing stability for that population, a review of services covered and access points for services and housing will need to be undertaken.

Prior to the 1115 waiver implementation, housing location, navigation, and tenancy sustaining services have been grant-funded in the state. As these providers begin exploring and understanding what Medicaid could entail, they will need infrastructure and capacity-building support. While decision-making on 1115 waiver infrastructure and capacity-building funding remains unknown, providers are also witnessing the growth of social care networks and community care hubs.

PART FOUR: RECOMMENDATIONS

The Crosswalk takes a comprehensive look at publicly available documents to determine the degree to which Medicaid does or does not provide the services required for quality supportive housing. Currently, Illinois leaders are planning on how best to implement the state's latest 1115 waiver program. Given the unique opportunity to shape the implementation of an important program, the following recommendations offer ways that HFS and its state partners can ensure the success of this benefit by engaging in a comprehensive state-wide approach to funding and tracking outcomes in supportive housing.

Coordination of Local and State Housing Access Points with the new 1115 waiver Services

To ensure the 1115 waiver services result in Medicaid members getting successfully connected housing solutions, it is critical to coordinate local and state housing access points to align with the new HRSN benefits. This coordination needs to align populations, access paths/points, guidance on braiding of funding opportunities, addressing data system issues and quality monitoring. The state has a unique opportunity with the new 1115 waiver, to expand quality supportive housing capacity. But that outcome will only be possible if housing resources are coordinated and aligned with the new services in a variety of ways including:

Populations: Those eligible for 1115 waiver housing support services must also be eligible and prioritized for affordable and supportive housing long term rental assistance. Eligibility for the services and the housing needs to be aligned to ensure providers are providing services that result in Medicaid members accessing housing successfully as the desired priority outcome.

Access points: The burden for coordination of housing and services funding should operate at the systems level and not rely on providers and those needing assistance to coordinate resources. There are multiple ways to access affordable and supportive housing in Illinois, where each has its own eligibility criteria and application process. These paths include but are not limited to coordinated entry. While coordinated entry is extremely important, the State should also consider additional housing resources that people may be eligible for, including SRN/811, HOPWA, HUD multi-family and senior housing resources and local public housing authorities.

Financial guidance: Providers that are new to billing Medicaid will need some additional support and guidance on appropriate and allowable ways to braid different funding opportunities. While Medicaid is needed to scale up existing housing support services, we also know that supportive housing programs will not be able to assume all tenants will have Medicaid or will be eligible for the housing support services. As a result, all providers will need to understand how to effectively braid different funding sources in order to be sustainable.

Data Systems: To maximize efficiency and consistency in data collection and reporting, ensuring providers are entering data into only one system will be extremely beneficial.

Quality Monitoring: When looking at braiding funding, it will be helpful to create systems where providers are only answering to an integrated quality monitoring process that takes into account requirements from both sectors.

CSH recommends that the state utilized the existing 1115 Waiver Housing Supports Workgroup to test processes for aligning housing resources with these new Medicaid services. The Illinois Office to Prevent and End Homelessness convenes all 19 Continuums of Care which could be utilized to identify and test processes along with the SRN/811 housing waitlist system. The state should convene pilot projects between housing sector partners who are interested in collaborating with 1115 services providers to create new SH pilots that will develop the best ways to integrate these two systems to address fragmentation between sectors. The goal for the pilots is to develop sample integrated:

- Populations served
- Access points workflows
- Guidance on allowable braided funding
- Data needed to be collected by both systems
- Quality Metrics

Coordination of Local and State Supportive Housing Service Funding

CMS requires that Medicaid resources do not duplicate or supplant other available funding streams, and that Medicaid aligns with other programs to expand or fill gaps where appropriate. CSH estimates that robust Medicaid-covered supportive housing services could cover up to 60% of a supportive services budget per project, depending upon a variety of factors. Upcoming changes with HR 1 impacting eligibility and redetermination will also impact the number of individuals who are Medicaid eligible. Factors include aligned populations, project-based vs scattered site (higher % for site based with limited travel needed between units) and providers who can braid funding in a compliant and quality manner. The other 40% or more of services budgets will need to be covered by flexible grants and contracts to address the clearly delineated gaps, including:

- Outreach and engagement (particularly recognizing people encountered in outreach do not have active Medicaid and may not be immediately eligible for these services).
- Benefits navigation to assist individuals in accessing Medicaid, SNAP, and Social Security if indicated.
- Services for people who are not able to be immediately Medicaid enrolled.
- Services for people who are not eligible for Medicaid or who are working on their citizen documentation.

- Services for people who have Medicaid, but do not meet the social and medical criteria for housing support services.
- Warm hand-off to ensure coordination of services and care if a person changes MCOs
- Services provided by agencies that provide population-specific services that do not have the capacity to become Medicaid billing agencies and/or to partner with those that are.

CSH recommends the state create braided funding guidance to outline common housing and services funding in the state and what funding sources can be compliantly braided together to create new supportive housing. The guidance should outline state and federal funding streams that cover supportive housing services. The guidance could also point to local services funding opportunities as they exist. The guidance should then outline what funding streams can be braided and highlight critical compliance and audit considerations that agencies must consider as they set up their financial management systems. By offering such specific guidance, more providers, including those who are less risk averse, are likely to offer services using braided funding. A concrete example of the guidance needed would be when agencies are Medicaid billers but also have Illinois Department of Human Services (IDHS) PSH service grants. Providers will need clear instruction to ensure providers understand service grant dollars are only utilized after Medicaid- meaning those grant dollars are only utilized for tenants that are not Medicaid eligible or actively enrolled in the Medicaid program.

CSH also recommends the state assess if the current implementation plans and service definitions for housing support services will impact supportive housing creation. Quality supportive housing is a three-legged stool of financing that includes capital to build, operating subsidies and services funding.

Provider Capacity Building

Providers who have expertise in housing finance, operations, and working effectively with those experiencing homelessness and housing instability are seldom also expert Medicaid billers. CSH applauds the state in its vision for a Third-Party Administrator (TPA) that can ease the burden of Medicaid billing for many non-traditional Medicaid agencies. CSH has found that for a provider with no Medicaid billing infrastructure, making this transition commonly takes approximately 18 months to 2 years. Agencies wishing to grow this line of business will need start-up funds to begin this effort. States have received capacity building funds from their 1115 waiver and CSH recommends that a process be implemented to support agencies that are experienced and grounded in the housing world but need financial support to make this transition.

Training and Technical Assistance

CSH recommends investing in provider engagement work well before go-live, to bring information and knowledge to the housing sector in Illinois. Social services providers that are already experienced in pre-Tenancy supports and tenancy/housing support services need additional engagement and support in Q1

While funding to support 1115 implementation is vital to getting provider buy-in, capacity-building funds *alone* are not sufficient to support providers who are new to billing Medicaid or new to providing services under a new demonstration. CSH recommends that tailored training sessions and ongoing, provider-specific technical assistance resources are available to support providers that decide to become billers, as they onramp to provide new Medicaid services. Training and tools should be targeted to Illinois's current network of quality supportive housing providers. Illinois is leaning into this need via the Medicaid Technical Assistance Center (MTAC) for new provider onboarding resources and supportive housing provider specific TA that is anticipated to be offered through the Homelessness Education Technical Assistance Center (HETA).

and Q2 of FY27, so they can make informed decisions about participating as Medicaid providers. Becoming a Medicaid biller requires significant investment of time and resources; creating opportunities for providers to learn, ask questions, and conduct their own ROI assessment is necessary if the State would like to see these providers become effective and successful Medicaid service providers.

CONCLUSION

CSH applauds HFS, OPEH and their collaborative partners for their efforts to more effectively align the health and housing sectors and for their emphasis on increasing supportive housing services capacity and quality in the state. The state has clear foundational building blocks for better serving its most impacted residents who currently fall through the cracks. In line with the goals of the State's latest 1115 waiver application goals and objectives, this report offers an analysis that confirms the need for a supportive housing services benefit for a broader set of Medicaid beneficiaries. Creating this benefit, building provider capacity, and focusing on state-wide housing and services coordination would drive changes that would be beneficial to the State, local jurisdictions, providers, and Illinois residents who are most in need.