Using Home and Community Based Services (HCBS) for Supportive Housing

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CSH

ABOUT CSH

CSH (Corporation for Supportive Housing) advances affordable housing aligned with services by advocating for effective policies and funding, investing in communities, and strengthening the supportive housing field. Since our founding in 1991, CSH has been the only national nonprofit intermediary focused solely on increasing the availability of supportive housing. Over the course of our work, we have created more than 512,500 units of affordable and supportive housing and invested more than $2.2 billion in communities. Our workforce is central to accomplishing this work. We employ approximately 170 people across 30 states and U.S. Territories. As an intermediary, we do not directly develop or operate housing but center our approach on collaboration with a wide range of people, partners, and sectors. Visit us at www.csh.org.

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I. INTRODUCTION

This paper shares critical information about the Home and Community Based Services (HCBS) program and how it can expand and enhance services in supportive housing.[1] HCBS services help individuals live comfortably in their own homes, despite challenges commonly faced by people with disabilities and all of us as we age. HCBS will be an essential supplementary resource to help supportive housing tenants thrive in their community at all ages.

The federal Center for Medicaid and Medicare Services or CMS has also made clear that tenancy support services, or the services in supportive housing *are* HCBS services.[2] The aging of the American population is well documented, particularly the growth in older adults experiencing homelessness.[3] Some of them experience chronic homelessness, while others who remain in institutional, congregate, and other long-term care settings have not been able to piece together the housing and services needed to return to their community, which is contrary to Olmsted guidance. Individuals recently released from long-term incarceration may have limited community connections or lack the required skills and networks to gain living-wage jobs and market-rate housing. Others have worked low-wage, often physically demanding, jobs for much of their lives and are priced out of the market as housing costs rise. No matter the history or population, the supportive housing industry is committed to serving people in need in their communities. Older adults are no exception.

As Americans live longer lives, all public systems, including supportive housing, will face opportunities and challenges. One such challenge will be understanding and navigating the public benefits available to support aging people, people with disabilities, and/or people earning low incomes. This subject will be crucial as the number of Americans aged 65 and older double over the next 40 years, and those aged 85 and older quadruple between 2000 and 2040.[4] Individuals with experiences of homelessness, long-term incarceration, institutionalization, or significant traumas tend to experience a premature onset of geriatric conditions, including physical and functional limitations that occur at higher rates and younger ages compared to their peers. Persons living in supportive housing or experiencing homelessness are more likely to have multiple chronic conditions. However, supportive housing residents are also less likely to have family or other 'natural supports' than other low-income populations. A higher percentage of those experiencing homelessness age out of the foster care system, meaning no family member could support them in the transition to adulthood. In 2019, AARP estimated the national contributions of family caregiving at $470 billion.[5]

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1 https://www.medicaid.gov/medicaid/home-community-based-services/index.html
2 https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf
3 https://www.nytimes.com/2020/09/30/magazine/homeless-seniors-elderly.html
4 https://www.urban.org/policy-centers/cross-center-initiatives/program-retirement-policy/projects/data- warehouse/what-future-holds/us-population-aging#:~:text=The%20number%20of%20Americans%20ages,The%20nation%20is%20aging.
5 https://www.aarp.org/content/dam/aarp/ppi/2019/11/valuing-the-invaluable-2019-update-charting-a-path- forward.doi.10.26419-2Fppi.00082.001.pdf

The late baby boomer demographic, who will reach age 65 in 2029, is the most likely to experience chronic homeless.[6] These demographic changes also present an opportunity for the supportive housing industry, which remains committed to choice and communities thriving to help ensure that older adults and future generations can access the support they need. The values of the supportive housing industry align well with the goals of community integration and choice, which have been central to the disability rights field even before the Supreme Court's Olmsted decision.[7]

As local homelessness sector Coordinated Entry Systems continue to prioritize persons with the most challenging health-related issues for supportive housing, the demand for supportive housing and more intensive service models in housing will continue to grow. In addition, states continue to rebalance their aging systems, moving from an approach that relies on institutionalization to one that offers persons a Community First Choice option.[8] Agencies planning for long-term sustainability are also aware of these population trends and are planning on delivering, or partnering to deliver, the services that these residents will need to 'age in place.' HCBS can play a critical role in all of these efforts.

II. THE BASICS

HEALTH CARE COVERAGE

When working with older adults, their advocates need to ensure they can access all of the public sector benefits for which they are eligible. Supportive housing tenants tend to have low incomes and high rates of disability, making them eligible for Medicaid, the public health care insurance for persons with low incomes.[9] But as tenants age and reach the age of 62, they may also be eligible for Medicare.[10] Persons who are eligible for both Medicaid and Medicare are called "Dual Eligibles." Since Medicare is available to all Americans, the program has a variety of built-in cost-sharing mechanisms, meaning people pay out-of- pocket for some healthcare-related costs. For eligible people, Medicaid can help cover many of these costs. Those who do not qualify for Medicaid may still be eligible for other Low Income Subsidies, also called "Extra Help," to help pay for these out of pocket and non- covered expenses, such as prescription drugs.[11] All older supportive housing residents should participate annually (or at lease up) in a Benefits Check Up , such as that created by the National Council on Aging, or engage with a similar program.[12]

Supportive housing residents must enroll in the right healthcare coverage to receive the HCBS services described below. Individuals can receive support in deciding what Medicare delivery system (traditional Medicare versus a Management Care Organization or MCO) best supports their needs. Assistance is also available to help choose a health plan, called the Medicare Advantage plan, for an MCO option. Residents can access these services by working with their State Health Insurance Program, or SHIP.

6 https://www.aisp.upenn.edu/wp-content/uploads/2019/01/Emerging-Crisis-of-Aged-Homelessness-1.pdf
7 https://www.ada.gov/olmstead/olmstead_about.htm
8 https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-authorities/community-first-choice-cfc-1915-k
9 https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network- MLN/MLNProducts/Downloads/ProgramBasics.pdf
10 https://www.medicare.gov/basics/get-started-with-medicare
11 https://www.cms.gov/Medicare/Prescription-Drug-Coverage/LimitedIncomeandResources
12 https://www.benefitscheckup.org/

HOME AND COMMUNITY BASED SERVICES (HCBS)

The goal of the Home and Community Based Services (HCBS) program is to keep people in their homes for as long as possible, despite disabilities and the challenges that can come with aging or disabilities. HCBS offers additional supports, such as home health and personal care services, as alternatives to entering nursing homes and other institutional care settings.

HCBS is part of a state's Long-Term Services and Supports (LTSS), or Long-Term Care (LTC) program, which is an umbrella program under Medicaid that also includes Nursing Homes. Medicaid is said to have a 'structural bias towards institutional care' because nursing home care is a benefit that the federal government requires states to offer through Medicaid. HCBS, however, is an **optional** benefit. States can choose what services they offer and what populations. For example, the 1915(c) Medicaid waiver program may have a long waitlist of persons who have proven eligibility because the state is allowed to limit the number of people who receive the services, and most states have long waiting lists for these services. As a result, many people receive institutional care even though they could live in the community with the right housing and service supports.

To effectively partner with states, advocates need to understand the state's perspective and how they design, finance and operate their LTSS or LTC program. States typically develop their HCBS programs with a few key decision points in mind:

- Who they serve, commonly called **populations**. Most states' HCBS programs serve people who are aging, people who have significant physical disabilities and people who have intellectual or developmental disabilities (ID/DD). Other populations such as those with mental illness may be included as well. States are beginning to experiment with including persons with substance use disorders in these programs as well.

- What **services** they offer, and how much of those services are available. Services commonly included in HCBS programs include:[13]
    - Home health care, such as:
        - Skilled nursing care
        - Therapies: Occupational, speech, and physical
        - Dietary management by registered dietician
        - Pharmacy
    - Durable medical equipment
    - Case management
    - Personal care
    - Caregiver and client training
    - Health promotion and disease prevention
    - Hospice care

[13] https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS-TA-Center/info/hcbs

The language used to describe benefits can be tricky. It is important to note that case management, as defined by HCBS, is not the same as the case management that is commonly used in homelessness or behavioral health fields. Case management in HCBS typically means an assessment of needs and ensuring that needs are being met, rather than "hands-on" support. Caseloads are generally very high, for example 1 staff to 75 or more service recipients. Hands-on support is delivered by home health agencies staff, not by case management staff. States also differ in their delivery systems, which means that as of April 2021, 22 states currently offer LTSS via Managed Care (M-LTSS) and the remaining states use a Fee for Service (FFS) delivery system.[14] Several states, including California, are transitioning to an M-LTSS system, and that transition can take as long as 3-5 years.

III. THE POLICY AGENDA

Medicaid authorities for HCBS

Medicaid authorities are the different components of the federal Medicaid program that offer optional strategies for how states can design their Medicaid program to meet the population's needs and state policy goals. Different Medicaid authorities have different rules and requirements. CSH has created over a dozen Medicaid Crosswalks that are state-specific policy analyses of service offering and target population, along with alignment and potential alignment among quality supportive housing services and providers. Most states began their programs with 1915(c) waivers that serve persons who meet the state's definition of an institutional level of care. This waiver gives states the ability to waive a variety of Medicaid requirements including the requirement to offer all services to persons who qualify.[15] This waiver is why Medicaid, despite being an entitlement program, can have a waiting list for specific services or populations. Advocates estimate that over 650,000 people have been approved for services, but remain on waiting lists, often in institutional care.[16]

HR1, the 2025 budget reconciliation law gives states more flexibility to design their HCBS programs in general and their 1915(c) waivers specifically. After July 2028, persons no longer need to meet Nursing Home Level of Care criteria. Rather states can design their own "Needs Based Criteria" to determine who qualifies for these services.

States may also use the 1915(i) State Plan Amendment, or SPA Authority, to deliver housing support related services. At the start of 2026, Connecticut, Washington, DC, Kentucky, Minnesota, New Hampshire, North Dakota and Wisconsin's Medicaid programs have been approved to include these benefits. In developing these benefits, the challenge for states is developing "Needs-Based Criteria" to determine who qualifies for these benefits.

[14] https://www.kff.org/other/state-indicator/total-medicaid-enrollment-in-managed-long-term-services-and-supports/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[15] https://www.macpac.gov/subtopic/1915-c-waivers/#:~:text=1915(c)%20waivers-,Waivers,an%20alternative%20to%20institutional%20care.

[16] https://www.kff.org/medicaid/more-than-half-a-million-people-in-the-u-s-are-on-waiting-lists-for-medicaid-home-and-community-based-services-but-waiting-lists-can-both-overstate-and-understate-unmet-need/#:~:text=Other%20Findings%20From%20Our%2050,as%20the%20resources%20it%20commits

From a budgetary perspective, states will want to have a good understanding of how many people will qualify and what those services will cost. This information is important because the 1915(i) authority requires 'statewideness,' meaning everyone who can prove they meet the Needs-Based Criteria must be able to access the service. Therefore, states need to know what the cost of that service is as they develop budgets and requests to their legislatures.

Many states may be looking to use their HCBS Programs to fund housing support services, as they look to grow their supportive housing programs. States are looking to decrease institutional care for several important reasons. For example: nursing home care is far more expensive than HCBS; challenges of COVID management in institutional settings; current or potential Olmsted litigation; or simply honoring the preferences of Medicaid beneficiaries. No matter the reason, states are looking to expand supportive housing options for a variety of populations. As states focus more on addressing the needs of their aging residents, they employ a strategy of "Rebalancing," meaning increasing access to HCBS so people can remain in the community and the need for institutional settings can be reduced. States may also have a Money Follows the Person (MFP) program,[17] which works to move people out of institutional settings and into the community. Your state's MFP coordinator is often a wonderful ally for developing more supportive housing, as they have seen firsthand how many people could return to, or remain in, the community if adequate capacity for quality supportive housing was available.

IV. IN PRACTICE

SERVICES ACCESS

The process of accessing HCBS services commonly differs depending upon the state, and the needs and demographics of the individuals served. For states with a Managed Care, LTSS delivery system model, the managed care plan may often be the first step in accessing services. An individual's current Medicaid health plan may be beneficial in helping them be assessed for HCBS services because without HCBS services, the individual's health remains unstable and expensive to maintain. Persons with intellectual or developmental disabilities (ID/DD) may be connected to services via a county office for ID/DD services. Moreover, persons who are aging may also be connected to services via your community's **Area Agency on Aging**, commonly called the local Triple A.[18]

The federal Administration for Community Living or ACL's Eldercare Locator can help you find your local office. Communities also commonly have an **Aging and Disability Resource Center, or ADRC,** that can help link a person to services, and ACL's Eldercare locator also includes information on these programs. Finally, **Centers for Independent Living, or CILs,** offer supports and services to ensure that people with disabilities remain in the community rather than living in institutions.[19] Staff at all these programs, can be important new allies in the work to develop additional supportive housing capacity in your community.

[17] https://www.medicaid.gov/medicaid/long-term-services-supports/money-follows-person/index.html
[18] https://acl.gov/programs/aging-and-disability-networks/area-agencies-aging
[19] https://acl.gov/programs/aging-and-disability-networks/centers-independent-living

WHAT THIS MEANS FOR RESIDENTS

Supportive housing programs both serve people as they age in place in their programs and accept referrals from an aging population. Some residents have lived in supportive housing for decades and their services needs have evolved. Other programs are required to take referrals from their community's Coordinated Entry System, which may prioritize serving people or households with older, frailer members. Whatever the reason, residents may need support to:

- Understand what services are available
- Access services
- Navigate structural or procedural barriers, including discriminatory behavior
- Ensure the quality of services received

WHAT THIS MEANS FOR AGENCIES

Supportive housing agencies may also choose to develop a new line of business and offer HCBS services in the community. This business development project will require a basic understanding of the program and services offered in your state, the needs of your residents, and the expertise, staff capacity, and funding available to develop a new line of business. CSH outlines three administrative models that agencies can pursue. Agencies may want to deliver and bill for services themselves, may want to partner with a mission-aligned community agency that offers the services your residents need, or agencies may wish to provide services themselves but contract out the billing functions. The pros and cons that agencies must consider are discussed in the referenced paper.[20]

HEALTH CARE'S STRUCTURAL BIAS TOWARDS INDIVIDUALS

All health care programs, including Medicaid, include a structural bias towards individuals. Health care has historically measured outcomes individually, rather than as a household or a community. Health care practice has focused mainly on individual practitioners offering individual care, individual procedures such as surgery, changing an individual's medication or behavior such as diet and exercises. Only the public health field and the burgeoning population health conversation, pioneered in the last decade, has grown beyond this structural bias.

The housing industry's basic unit of measurement can be a household, a building, a development, or a community. This misalignment between health care's individual focus versus the housing industry household and building focus, creates challenges as these two industries work to collaborate more often and more effectively. The housing sector may approach a health care funder for staff that are attached to a building rather than to individuals. Health care generally only attaches staff to an individual who qualifies for those services, and services are expected to follow the individual wherever they live.

For HCBS, this means that while particular residents who qualify can receive services, the building, development, or project may not have benefits attached for all residents. Projects that serve many tenants, or projects that serve seniors or communities exclusively with only a few health care payers, may overcome that structural bias via volume, but those examples remain limited.

[20] https://www.csh.org/csh-solutions/lending-community-investment/underwriting-medicaid-sourced-supportive-housing-services/

CONFLICT OF INTEREST (COI) REQUIREMENTS

The HCBS program includes a requirement for state programs to meet a conflict of interest requirement,[21] and every state must develop conflict of interest processes to establish operation of "conflict-free" case management.[22] A person is referred for services, deemed eligible by state-specific financial and functional criteria are met, and then the person is referred to an agency to develop a Person Centered Plan, or PCP.[23] Conflict free commonly dictates that the agency that creates the PCP cannot be the same agency that delivers the services. This requirement was made in response to a practice in which agencies would refer to all the services offered by their agency, but not to other services, limiting choice and options. Case Management in the HCBS field commonly refers to the work ensuring that services in the PCP are in place, rather than focusing on the more hands-on support that case management typically refers to in the homeless or behavioral health fields. Case Managers in the HCBS field commonly have a 1-75 or larger caseload and are seldom found in the community.

There are a few exceptions to the conflict free case management rule that vary state to state. For example, states have designated provider shortage areas in rural or frontier areas, and the COI standards do not apply in those communities. Agencies, such as the Native American tribal health agencies, may make a case for cultural-specific services, and if approved, COI requirements would be waived.

The structures of the HCBS system pose challenges for providers of supportive housing, but none are insurmountable. For example, most providers are commonly familiar and comfortable assessing needs and delivering services themselves. Therefore, coordinating care with a variety of other agencies can add administrative challenges. Persons who need services can often fall through the cracks as their case moves from eligibility determinations to services assessment to service delivery. Every step that is added to the process adds complexity that can prevent people from receiving the services they qualify for and need. These programs do not typically include navigation supports to help people navigate this multiple-step process, and the burden often falls on family members and natural supports, and thus creating further challenges for people without these supports. However, despite these barriers, HCBS remains the best strategy to align housing and services at scale.

The following graphic summarizes the basics of how people move through the eligibility and assessment processes to receive services. Each state has their own unique process. Some states have multiple processes and access points for different populations. Researching processes and breaking them down can help make them easier to understand. It can also be a way to start building partnerships in other systems, which will prove necessary when advocating effectively for the people your agency serves.

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[21] https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD040408.pdf

[22] https://aspe.hhs.gov/reports/descriptive-overview-summary-balancing-incentive-program-participating-states-baseline-1

[23] https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity- Education/Downloads/key-messages-Person-Centered-Service-Plans-%5BSeptember-2015%5D.pdf

THE SETTINGS RULE

The HCBS settings rule, finalized in 2014,[24] can be challenging to understand, but the law aligns with supportive housing values and precedents. The rule was established to address the fundamental importance of ensuring that people have the right to choose where they live. It also ensures that people receive the services they need to thrive while residing in the most community-integrated setting possible. These requirements can be challenging for supportive housing providers, who often offer an integrated housing and services package. It can also be challenging to ensure quality services and coordination of care when services are not integrated. However, supportive housing shares the value of choice, and therefore, CSH believes housing providers can work within the final HCBS Settings rule as services are expanded via HCBS. However, the traditional models of financing services will expand and change.

The settings rule "creates a more outcome-oriented definition of home and community-based settings that focuses on the nature and quality of individual experiences."[25] Each state, within each HCBS waiver or SPA agreement between CMS and the state, must submit a plan to CMS regarding how the state will ensure that the settings rule is being complied with for all persons receiving HCBS services.

[24] https://www.medicaid.gov/medicaid/home-community-based-services/guidance/home-community-based- services-final-regulation/index.html

[25] IBID

A compliant setting includes a variety of characteristics including:

- The setting is integrated into, and supports full access to, the greater community
- The setting is selected by the individual from among other options
- The setting ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint
- The setting optimizes autonomy and independence in making life choices
- The setting facilitates choice regarding services and who provides them
- The setting provides a lease, privacy, choice of roommates, openness to decorating, access to food at any time, visitors at any time, and is physically navigable.

These characteristics are also characteristics of quality supportive housing, and alignment with the settings rule is likely to be found, as states work to determine service models. Each state has a process for determining compliance, and the administrative burden of proving that compliance may impact service providers. Proactive planning and engagement with states to address these issues at the system level can help to reduce these burdens.

V. CONCLUSION

As the average age of individuals in our communities rises, the HCBS program will be an increasingly important part of efforts to improve access to various settings, including affordable, service-enriched supportive housing. While the program can be complex to understand and navigate at the individual, program, and system level, the values and intent of HCBS are aligned with quality supportive housing. In addition, the at-home services HCBS allows for are essential to help people successfully age in place and thrive in community. This primer is designed for housing and homelessness sector partners to better understand the program and how these services can be made available for those they serve.

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