Report to Congress

Innovative State Initiatives and Strategies for Providing Housing-Related Services and Supports under a State Medicaid Program to Individuals with Substance Use Disorders Who Are Experiencing or at Risk of Experiencing Homelessness

As Required by the
Substance Use-Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities Act (Pub. L. 115-271)
from the
Department of Health and Human Services
Office of the Secretary

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Secretary of the Department of Health and Human Services
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Executive Summary

This report is provided in accordance with section 1017 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (Pub. L. No. 115-271), enacted on October 24, 2018, herein referred to as the "SUPPORT Act." Section 1017 of the SUPPORT Act directs the U.S. Department of Health and Human Services to issue a report to Congress on innovative state initiatives and strategies for providing housing-related services and supports under a state Medicaid program to individuals with substance use disorders (SUD) who are experiencing or at risk of experiencing homelessness.

The background section describes the impact of SUD on Medicaid beneficiaries and the relationship between SUD and homelessness and includes references to existing research and literature providing context about the impact of SUD and homelessness on health care utilization. The background section also establishes a conceptual framework for housing supports and services and housing stability.

This report focuses on five state Medicaid programs—Arizona, California, Maryland, Pennsylvania, and Washington State—in addition to highlighting several local programs across multiple other states. Case studies providing detailed descriptions of the listed five state programs are included in the appendix.

As required by section 1017(b)(1) of the SUPPORT Act, this report details existing methods and innovative strategies developed and adopted, with examples from the above mentioned states, that have achieved positive outcomes in increasing housing stability for Medicaid beneficiaries with SUD who are experiencing homelessness or are at risk of experiencing homelessness who are receiving treatment for substance use disorders in inpatient, residential, outpatient, or home-based and community-based settings, transitioning between SUD settings, or living in supportive housing or another model of affordable housing. A number of state program outcomes show favorable results: high housing retention rates, reductions in emergency services utilization, reductions in inpatient admissions, increased connection to primary and behavioral health care, and overall reduced health care expenditures for program participants. Several innovative strategies, broadly adopted by all five state programs, were identified: integrated care coordination strategies, peer support models, funding coordination strategies, payment models, and data strategies, among others.

As required by section 1017(b)(2) of the SUPPORT Act, this report also details strategies employed by Medicaid managed care organizations, hospitals, accountable health care organizations, and other care coordination providers to deliver housing-related services to individuals with SUD who are experiencing or are at risk of experiencing homelessness and to coordinate services provided under state Medicaid programs across different treatment settings. These entities appear to be particularly focused on expanding services to holistically improve health outcomes for high-need, high-cost Medicaid-eligible individuals, while averting costs to health care and public systems.

As required by section 1017(b)(3) of the SUPPORT Act, this report details innovative strategies and lessons learned by states with Medicaid waivers approved under sections 1115 or 1915 of the Social Security Act (Act), including challenges experienced by states in designing, securing, and implementing such waivers or plan amendments; how states developed partnerships with other organizations such as behavioral health agencies, state housing agencies, housing providers, health care services agencies and providers, community-based organizations, and health insurance plans to implement waivers or state plan amendments; and how and whether states plan to provide Medicaid coverage for housing-related services and supports in the future, including by covering such services and supports under state Medicaid plans or waivers.

States are increasingly testing, evaluating, and advancing best practices around providing housing-related and recovery services and supports for Medicaid-eligible individuals. Few states have chosen the section 1915(c) home and community-based services (HCBS) waiver program authority to cover housing-related services for individuals experiencing or at risk of experiencing homelessness, since individuals would need to meet an institutional level of care, among other requirements, to qualify. However, states are exhibiting a growing interest in section 1915(i) State Plan Amendments (SPA) which allow states to provide HCBS to individuals who meet state-defined needs-based criteria that are less stringent than institutional criteria and, if chosen by the state, target group criteria. Many states are exercising the flexibility through demonstration projects under section 1115 of the Act to test new approaches to providing Medicaid coverage of housing-related services and supports for individuals who are experiencing or are at risk of experiencing homelessness with a focus on HCBS-like services under these demonstrations. As further required by section 1017(b)(3), this report also describes challenges

experienced by states in designing, securing, and implementing housing-related services and supports under section 1115 demonstration authority and section 1915 authority. States have responded to challenges by developing and strengthening partnerships at the local, state, and federal levels.

States can use several different federal authorities to cover services that may assist an individual with SUD who is experiencing homelessness or at risk of homelessness with gaining access to and maintaining housing as well as optimizing community integration. As directed by section 1017(b)(4) of the SUPPORT Act, this report details existing opportunities for states to provide housing-related services and supports under sections 1115 or 1915 of the Act or through a State Medicaid plan amendment, section 1945 health home state plan benefit, section 1915(b)(3) waiver programs and risk-based managed care, section 1915(c) and section 1915(i) HCBS programs, and section 1115 authority. States have flexibility to cover a variety of housing-related services and supports under these different authorities; however, the services authorized under one Medicaid program may not always be the same as those authorized under another one. An example is the Assistance in Community Integration Service pilot program, which promotes supportive housing and other housing-related supports under Medicaid for individuals with SUD and for which Maryland has a waiver approved under section 1115 authority to conduct the program. Medicaid can also be an integral part of a collaboration with other community-based programs.

Finally, as required by section 1017(b)(5) of the SUPPORT Act, this report details innovative strategies and partnerships developed and implemented by state Medicaid programs to identify and enroll eligible individuals with SUD who are experiencing or are at risk of experiencing homelessness in state Medicaid programs. Several Centers for Medicare & Medicaid Services (CMS) regulations and other policies regarding enrollment procedures in state Medicaid programs provide flexibility to states to address some of the more unique needs of individuals who are experiencing homelessness. Several states have initiated effective strategies to identify individuals who are experiencing homelessness by partnering with homeless services providers, hospitals, managed care organizations, and others. Some states are also developing programs that connect with individuals who are at risk of homelessness as they exit correctional, behavioral health, and other institutional settings.

I. Introduction

The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (Pub. L. 115-271) (SUPPORT Act) was enacted on October 24, 2018. Section 1017 of the SUPPORT Act requires the Secretary of the U.S. Department of Health and Human Services to issue a report on innovative state initiatives and strategies for providing housing-related services and supports under a state Medicaid program to individuals with substance use disorders who are experiencing or at risk of experiencing homelessness.[1] This report is intended to respond to this requirement.

II. Background

a. Impact of Substance Use Disorders

Substance use disorders (SUD) affect the lives of millions of Americans in the general population, including many individuals enrolled in the Medicaid program. SUD occurs when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home. In 2018, approximately 20.3 million people aged 12 years or older had a SUD in the past year. In 2018, an estimated 2.0 million people had an opioid use disorder (OUD), which includes 1.7 million people with a prescription pain reliever use disorder and 0.5 million people with a heroin use disorder.[2]

The Centers for Medicare & Medicaid Services (CMS) estimates that nearly 12 percent of Medicaid beneficiaries over age 18 years have a SUD,[3] and the Henry J. Kaiser Family Foundation estimates that 4 out of 10 non-elderly adults with OUD are covered by Medicaid.[4] "Medicaid beneficiaries have been disproportionately affected by the opioid epidemic, accounting for roughly half of all opioid-related overdose deaths in some states. Compared to privately insured individuals, Medicaid beneficiaries age 18–64 have a higher rate of opioid use disorder (OUD) and are prescribed pain relievers more often than individuals with other sources of insurance. The introduction of less expensive, more potent opioid alternatives, such as fentanyl,[5] also has resulted in a higher risk of overdose for Medicaid beneficiaries."[6]

b. Intersection of Substance Use Disorder and Homelessness

A growing body of research has contributed evidence that SUD involving alcohol and illicit drugs are strongly associated with homelessness. A study of individuals living on the street and in shelters in Boston found that substance use contributed to high mortality rates. Drug overdose was the leading cause of death. Opioids were associated with 81 percent of overdose deaths and alcohol was identified as a co-occurring substance in 32 percent of drug overdose deaths.[7] In another study, risk factors for long-term homelessness among newly homeless men and women in New York City shelters were analyzed, revealing that about half of the study participants had a lifetime SUD diagnosis. Additionally, participants who had a lifetime history of drug treatment experienced a longer duration of homelessness.[8] Likewise, the prevalence of substance use among homeless youth is well documented. Substance use among youth between

12 and 24 years of age who are experiencing homelessness has been reported as two to three times higher than that found among non-homeless youth.[9] Evidence suggests that individuals who experience rural homelessness report higher rates of alcohol use and domestic violence but lower rates of mental health disorders and drug use than the urban homeless population.[10]

Recent studies have shown that certain populations may be at risk for both homelessness and higher rates of SUD. Research suggests that homelessness is a significant problem among young people aging out of foster care, indicating elevated rates of mental health disorders as well as illicit substance use and dependence for this population.[11] According to National Inmate Survey data, more than half (58 percent) of state prisoners and nearly two-thirds (63 percent) of sentenced jail inmates met the criteria for drug dependence or abuse.[12,13] Across the country, over 10 percent of people released from prisons and jails face homelessness upon reentry into the community —a percentage that could be as high as 50 percent in large, urban areas.[14] A recent study of homeless adults aged 50 years and older identified a growing prevalence of substance use among older homeless adults, doubling since 2002. According to the study, older adults experiencing homelessness with SUD are at a higher risk of remaining homeless and face higher health risks compared with younger adults.[15] Moreover, a 2019 study predicts a coming surge in the older adult homeless population due in large part to a birth cohort effect,[16] disproportionately affecting people born in the latter half of the post-war baby boom (1955–1965).[17] Further, the HOPE HOME Study revealed that increasing numbers of adults age 50 and over are experiencing homelessness for the first time, elevating the risk for chronic homelessness among older adults. In addition to the growth in numbers of Americans over age 50, the rise in older adults experiencing homelessness for the first time include factors such as higher proportions of low income older adults from ethnic and racial minority groups and the lack of affordable and accessible housing opportunities.[18]

The relationship between homelessness and SUD is complex. According to data analyzed from the Department of Veterans Affairs (VA) Homeless Operations Management and Evaluation System on approximately 121,000 veterans, 75 percent of individuals experiencing homelessness with a past-year SUD also had a co-occurring non-substance-related mental disorder.[19] Moreover, compared with the general population, people who experience homelessness are at greater risk of infectious and chronic illness and are also more often victims of violence, prior to becoming unhoused and when homeless. Individuals experiencing

homelessness also have a mortality rate four to nine times higher than those who are not homeless.[20]

According to the 2019 Annual Homeless Assessment Report to Congress, which is a point-in-time estimate of the number of sheltered and unsheltered people in the United States reported by the U.S. Department of Housing and Urban Development (HUD), 567,715 people experienced homelessness on a single night in 2019. Just under two-thirds (63 percent) were staying in sheltered locations—emergency shelters or transitional housing programs—and just over one-third (37 percent) were in unsheltered locations, such as on the street, in abandoned buildings, or in other places not suitable for human habitation. Nearly half of all people experiencing homelessness in the United States were in one of three states: California (27 percent); New York (16 percent); or Florida (5 percent). California and New York had the largest numbers of people experiencing homelessness and high rates of homelessness, at 38 and 46 people per 10,000. Hawaii and Oregon also had very high rates, with 45 and 38 people per 10,000.[21] States are further challenged by the fact that federal housing assistance is a limited resource that serves just one out of every four very low-income renter households.[22]

In 2019, HUD's homeless Continuums of Care (CoCs)[23] reported that 88,873 (16 percent) of homeless individuals experienced "chronic substance use."[24] Because approximately 18 percent of the total were children under age 18 years, the percentage of those aged 18 years and older with chronic substance use is likely higher than 16 percent. Of all individuals served by HUD CoC programs with chronic substance use disorder, nearly half were unsheltered, slightly more than a third were in an emergency shelter, and the remainder were in transitional housing.[25]

c. Health Care Utilization and Costs Related to Substance Use Disorder and Homelessness

Multiple studies have concluded that individuals experiencing one or more conditions of homelessness, mental health disorders, and/or SUD have higher rates of emergency department (ED) use, hospitalization, and encounters with publicly funded services. An October 2017 brief from the Agency for Healthcare Research and Quality reported that individuals experiencing homelessness were more likely than members of the general public to use ED services. Compared with the general population, individuals experiencing homelessness were three times more likely to use an ED at least once in a year.[26] According to a 2010 study of approximately

7,000 Massachusetts Medicaid members who received services from a Federally Qualified Health Center (FQHC) Health Care for the Homeless program,[27] individuals experiencing homelessness with co-occurring mental health disorder and SUD were at greatest risk for frequent hospitalizations and ED visits.[28]

The City of Denver, Colorado is implementing an initiative targeting individuals with SUD experiencing homelessness and other challenges that result in frequent criminal justice system involvement and high utilization of ED services. One intent of the initiative is to reduce emergency health system costs by offering preventive services. The Denver Crime Prevention and Control Commission has estimated that "chronically homeless frequent users of the criminal justice and emergency health systems spend an average of 59 nights in jail each year and visit detoxification facilities a total of more than 2,000 times in a given year. The frequent interaction of individuals with SUD experiencing homelessness with jails, detoxification facilities, and other systems, such as emergency care, cost the City an estimated $7.3 million a year."[29]

Numerous additional studies have documented that supportive housing[30] for individuals experiencing chronic homelessness reduces ED utilization. Research in Chicago revealed that housing and supportive services led to a 29 percent reduction in hospital days and a 24 percent reduction in ED visits.[31] A study in Oregon found a 55 percent reduction in Medicaid claims for individuals experiencing homelessness with high cost and complex healthcare needs one year after they transitioned to stable housing with access to integrated services.[32] A supportive housing program serving individuals experiencing chronic homelessness in Seattle with severe alcohol use disorder who made frequent use of crisis services was found to result in a large reduction in emergency health care expenses.[33] Over 90 percent of participants in the New York Frequent Users Service Enhancement[34] initiative, which provided supportive housing to individuals with frequent jail and shelter stays, remained stably housed after 12 months, reducing annual costs for crisis medical and behavioral health services by over $7,000 per person.[35]

d. Housing Stability

Addressing homelessness and housing stability is a complicated issue, especially for individuals with co-occurring mental health disorders and SUD, who are among the most vulnerable and hardest-to-house populations.[36] Individuals with SUD often face multiple barriers to achieving housing stability, especially in accessing and maintaining housing. Many

individuals with SUD have criminal records, credit issues, and outstanding rent or utility arrears that complicate and, in some cases, prevent access to housing.[37] The complexity of need among those with SUD who are experiencing or are at risk of experiencing homelessness may include behaviors that impair an individual's ability to be a safe and responsible resident, increasing the risk of eviction or discharge back into homelessness.[38]

Definitions and measures of housing stability are not standardized. A recent paper sponsored by HUD discussed the need for developing and validating a housing insecurity index to track trends in housing insecurity, build evidence about associated outcomes, and improve research about prevention and intervention programming.[39] HUD is designing a national housing insecurity research module to be implemented as a follow-on to the 2019 American Housing Survey.[40]

e. Housing-Related Services and Supports

Housing alone may not be sufficient to achieve housing stability for individuals with SUD who have more complex and co-occurring disorders.[41] Services and supports are needed to enable individuals to obtain and retain housing, and promote long-term stability, recovery, and improved health. Federal financial participation is not available to state Medicaid programs for room and board (except in certain medical institutions).[42]

For the purposes of this document, housing-related services and supports mean activities intended to help an individual achieve and maintain housing stability. The report describes how states have designed Medicaid benefits and discusses circumstances under which states may elect to provide Medicaid coverage for certain housing-related supportive services. This report also sets forth examples of emerging administrative procedures through which state Medicaid programs may partner with other public agencies and stakeholders to ensure access to a broader range of housing-related benefits for individuals in community settings. While Medicaid does not cover room and board costs or other benefits that generally are not authorized as home and community based services (HCBS), Medicaid can be an integral part of a collaboration with other programs that support individuals' ability to live and receive needed care, including services to address SUD, in their chosen community setting.

The report will discuss:

"(1) Individual Housing Transition Services - services that support an individual's ability to prepare for and transition to housing;

(2) Individual Housing & Tenancy Sustaining Services - services that support the individual in being a successful tenant in his/her housing arrangement and thus able to sustain tenancy; and

(3) State-level Housing Related Collaborative Activities - services that support collaborative efforts across public agencies and the private sector that assist a state in identifying and securing housing options for individuals with disabilities, older adults needing long term services and supports (LTSS), and those experiencing chronic homelessness."[43]

Federal financial participation is available under certain federal authorities for certain housing-related supports and services that promote health and community integration for Medicaid eligible individuals with SUD. Services such as case management under state plan authority may include linking individuals with SUD to any needed services, including to agencies that can assist them in finding and securing housing. Services such as rehabilitative services under state plan authority can help Medicaid-eligible individuals acquire or restore skills and functions that allow them to remain successfully in their homes. Section 1915(c) home and community-based services (HCBS) waiver programs can provide one-time community transition services for individuals transitioning from an institutional setting to a living arrangement in a more integrated residence where the individual is directly responsible for his or her own living expenses.

Many of the pre-tenancy supports needed by individuals with SUD who are experiencing or at risk of experiencing homelessness are similar to those that assist other populations to prepare for and transition to housing. These can include (1) conducting an individualized screening and housing assessment that identifies the individual's preferences and barriers for community residence, (2) developing an individualized housing support plan based on that assessment, (3) assisting with the housing search and application process, consistent with the individualized assessment and support plan, (4) ensuring that housing units are safe and ready for move-in, and (5) assisting in arranging for and supporting the details of move-in. This population may also require linkages to community-based resources that provide assistance with securing required documents and fees needed to apply for housing, resolve outstanding warrants and expunge eligible criminal histories from records, and make a reasonable accommodation request related to one's disability to a housing provider.

Tenancy sustaining services are provided once an individual is housed to help them achieve and maintain housing stability. These services may include (1) early identification and intervention for behaviors that may jeopardize housing; (2) education or training on the role, rights, and responsibilities of the tenant and landlord; (3) linkage with community resources to maintain housing stability; and (4) individualized case management and care coordination in accordance with the person-centered care plan and the individual housing support plan. Care coordination can include connecting the individual with needed Medicaid and non-Medicaid service providers and resources.

Most of the programs described in this report provide tenancy sustaining services to individuals residing in a supportive housing setting; some programs also serve individuals residing in sober/recovery housing if that is an individual's choice. Tenancy sustaining services may also be provided in transitional housing where the availability of affordable housing is limited, with the goal of assisting an individual to transition to and sustain tenancy in community-based affordable housing. A more detailed description of supportive housing, recovery housing, and transitional housing can be found in Appendix B.

Section VI of this report provides a more detailed description of existing opportunities for states to cover housing-related services and supports under various Medicaid authorities. States have flexibility in how they choose the array of housing-related services and supports that may be covered under certain Medicaid authorities; however, services authorized under one Medicaid authority may not always be the same as those authorized under another one. Payments for housing-related services provided in community-based settings may not include costs associated with room and board, unless a setting meets the definition of an inpatient facility type for which expenditures for room and board may be made under the state plan. Each highlighted innovative state strategy in section III of this report illustrates the collaborative activities that facilitate these approaches under the Medicaid program.

III. State Medicaid Programs Efforts That Have Increased Housing Stability among Medicaid Beneficiaries with SUD Who Are Experiencing or Are at Risk of Experiencing Homelessness (SUPPORT Act, Section 1017(b)(1))

This section describes efforts by state Medicaid programs that have increased housing stability among Medicaid beneficiaries with SUD who are experiencing or are at risk of experiencing homelessness and who are receiving substance use disorder treatment in inpatient, residential, outpatient, or home-based and community-based settings, who are transitioning between SUD treatment settings, or who reside in supportive housing or another form of affordable housing. It includes a review of descriptive studies, program evaluations, scientific or gray literature, and an analysis of structured telephonic interviews[44] with staff from three state Medicaid programs (California, Maryland, and Washington) and two local programs (Maricopa County, Arizona, and City/County of Philadelphia).

To develop this report, subject matter experts under contract with CMS identified state and local programs providing Medicaid-covered housing-related services and supports to individuals experiencing or at risk of experiencing homelessness. Individuals with SUD were highly represented among participants in these programs. For the purposes of this report, CMS selected programs with preliminary or established outcome data, including programs that were in the process of collecting data as part of an ongoing evaluation. These programs are frequently cited throughout the report. While these outcomes are promising, these programs have not undergone rigorous evaluations and more research is needed to establish a causal relationship between participation in the programs and the positive outcomes described.

Each of the featured programs provides pre-tenancy support and tenancy sustaining services to individuals with SUD who are experiencing or are at risk of experiencing homelessness. Settings where pre-tenancy supports are provided vary by where individuals are residing at the time of referral to housing-related services. All programs interviewed receive referrals from local HUD-funded CoC Coordinated Entry Systems that identify and triage individuals experiencing homelessness. Several programs (e.g., Washington, Maryland, and California (Los Angeles County)) take referrals from SUD residential treatment facilities, detoxification facilities, sobering stations, and medical respite[45] providers. Timing of pre-tenancy service initiation also varies and typically occurs once a need for housing is established, whether individuals are living on the street, in shelters, upon preparing for exit or discharge from

inpatient or residential SUD treatment or other settings (e.g., hospitals), or once an individual is prioritized to receive an available housing subsidy or unit.

Overall Themes

States adopted a wide range of approaches to increase housing stability for Medicaid beneficiaries with SUD who are experiencing or are at risk of homelessness. Although each state is implementing unique programs designed to align with state priorities and to address local needs, common strategies and methods leading to positive outcomes were identified.

Several consistent program implementation, partnership, and funding themes emerged from the interviews and a review of evaluations and other materials on the five state and local programs providing Medicaid-covered housing-related services and supports to individuals experiencing or at risk of experiencing homelessness:

Implementation:

- States report that lack of affordable housing for program participants was a serious challenge.
- States generally target high-cost, high-need Medicaid beneficiaries; SUD was highly prevalent in this target population group.
- States offer section 1915(c) waiver and section 1915(i) state plan HCBS housing-related services and supports. Programs offer individual housing transition services and individual housing and tenancy sustaining services.
- Four out of the five states studied cover housing-related services and supports under a section 1115 demonstration.
- The State of Washington provides statewide coverage of housing-related services; California and Maryland limit coverage of housing-related services to specific geographic areas.
- States recognize supportive housing as a best practice and support Housing First[46] approaches.
- States provided technical assistance on Medicaid to housing providers.

Partnerships:

- States collaborate with federal, state, and local housing providers to increase affordable housing opportunities for program participants.

- States often utilize managed care organizations MCOs. Two programs (Maricopa County and Philadelphia) are administered directly by an MCO.
- States partner with local HUD-funded CoC entities, hospitals, and the criminal justice system around coordinating participant referrals, although the extent and nature of these partnerships vary locally in the programs implemented as pilots. Four of the five programs (all but Maricopa County) partner with FQHCs.

Funding

- To incentivize performance, three of the governments (California, Maricopa County, and Philadelphia) incorporate value-based purchasing into the reimbursement structure. States did not seek Medicaid administrative reimbursement for outreach or engagement activities and many of the programs rely on non-Medicaid funding sources for one-time move-in expenses; programs coordinate multiple federal, state, local, and philanthropic resources to fund these activities.

b. Positive Housing Stability and Health Outcomes

The selected programs (California, Maryland, Washington, Maricopa County, Arizona, and City/County of Philadelphia, Pennsylvania) are achieving measurable progress in increasing housing stability for individuals with SUD who are experiencing or are at risk of experiencing homelessness. Programs reported several examples of positive outcomes:

i. Housing Retention Rate

- California reports a housing retention rate for the Los Angeles County Whole Person Care (WPC) pilot program participants in Housing for Health (HFH) permanent supportive housing of 90 percent after 12 months and 86 percent after 24 months. The program had served 8,149 clients as of the end of December 2018. A majority of HFH clients were chronically homeless.[47]
- Mercy Care of Maricopa County, Arizona, reports that, of approximately 500 members served to-date with housing supports, over half remain housed. Program participants include individuals who were experiencing chronic homelessness, individuals experiencing more acute homelessness, and individuals who were at-risk of homelessness.[48]

- Data on Philadelphia's supportive housing program indicate that, of approximately 1,200 chronically homeless program participants placed in permanent supportive housing between 2009 and 2017, 89 percent remained in stable housing and were not using crisis services.[49] In March 2019, Pathways to Housing PA, one of Philadelphia's providers, reported that, out of 113 individuals residing in stable housing, there was a 96 percent housing retention rate.[50]

ii. Transitions from Supportive Housing to Less Intensive Housing

- Yakima Neighborhood Health Services, an FQHC and housing services provider participating in the Washington section 1115 Foundational Community Supports demonstration reports that, among 128 permanent supportive housing participants, many of whom were chronically homeless, the average length of tenancy in permanent supportive housing was 565 days. Among those that left permanent supportive housing, 73 percent went to permanent housing.[51]

iii. Reduction in Crisis Services Utilization

- Mercy Care of Maricopa County, Arizona, reports a 25 percent reduction in crisis service utilization among program participants between October 1, 2016 and September 30, 2017.[52]

iv. Impact on Inpatient Admissions

- California reports that 65 percent of Placer County's Whole Person Care pilot participants did not have a hospital readmission within 30 days during a 12-month period. The focus of the Placer County Pilot is on individuals who are homeless or chronically homeless.[53]
- In Washington, Yakima Neighborhood Health Services reported that 71 percent of clients who used medical respite services had no hospital readmission within 30 days. This suggests that receipt of medical respite services provides a stable medical setting for recuperation, alleviating the need for as much inpatient care as might otherwise follow.[54]

v. Follow-up after Inpatient or Emergency Department Admissions

- Mercy Care of Maricopa County, Arizona, experienced a 20 percent decrease in psychiatric hospitalizations for program participants. Early results also indicated, for the

subset of participants in scattered site permanent supportive housing, there were 155 fewer ED visits (per 1,000 enrollees) per quarter, compared to managed care organization (MCO) members not receiving housing services.[55]

- California reports that, during a 12-month period, 86 percent of Placer County's Whole Person Care pilot participants received a Comprehensive Complex Care Coordination visit within 7 days of inpatient discharge and 92 percent received one within 7 days of an ED visit.[56]

vi. Connection to Primary Care

- In Washington, Yakima Neighborhood Health Services reported greater connection to primary care for individuals residing in supportive housing who were enrolled in the Foundational Community Supports program, who averaged 6.37 FQHC visits in 2018, compared to all FQHC clients with an average of 2.2 visits per year.[57]

vii. Connection to Behavioral Health Care

- Philadelphia's Pathways to Housing PA program reported that 72 percent of individuals in its housing program are in medication-assisted treatment (MAT), 94 percent have seen a psychiatrist in the past year, and 100 percent are equipped with naloxone.[58]

viii. Reduced Health Care Expenditures

- A study of early results of the Mercy Care of Maricopa County's Comprehensive Community Health Program, focused on scattered site permanent supportive housing, found a 24 percent decrease (a savings of $4,623 per member per quarter in total cost of care after enrollment). Participant behavioral health services costs decreased 23 percent, and behavioral health facility costs decreased 46 percent.[59]
- The Philadelphia Community Behavioral Health MCO reported that use of community supports services and access to housing through housing choice vouchers resulted in $87 per eligible day in savings on behavioral health service costs measured from one year before voucher issuance to one year after individuals completed the leasing process.[60]
- Philadelphia's Journey of Hope transitional housing program, which serves a chronically homeless population, reported a 50 percent decrease in average daily per client behavioral health service costs from $90 in the year before services to $45 per day in year 3 after leaving transitional housing. Average daily costs for those who transitioned to

stable housing went from $91 per day to $34 per day. Average annual costs for all Journey of Hope clients decreased from $32,785 to $16,367 (50 percent) while annual costs for those transitioning to stable housing decreased from $33,083 to $12,491(62 percent).[61]

c. Target Populations

The five programs studied for this report target housing-related services to high-cost, high-need Medicaid-eligible individuals. Homelessness or a risk of experiencing homelessness was factored into service eligibility criteria for all five programs. Individuals with SUD experiencing or at risk of experiencing homelessness were highly represented among those served under the programs, most of which adopted the HUD *chronically homeless* definition.[62]

Washington State offers a supportive housing benefit titled Foundational Community Supports under a section 1115 demonstration. Eligibility is based on criteria that includes SUD and chronic homelessness. Service data from the program's first year revealed that more than 70 percent of those served identified a SUD treatment need in the past 24 months. Most of those enrolled with SUD had a co-occurring mental health disorder, and about 26 percent of supportive housing service beneficiaries had been chronically homeless.

Maryland targets housing-related supports offered under a section 1115 demonstration pilot, Assistance in Community Integration Services, to individuals with repeated incidents of ED use or hospital admissions **or** two or more chronic conditions. Individuals also must be either at risk of homelessness upon release from residential or hospital settings **or** at imminent risk of institutional placement. Maryland reports a majority of participants in a rural Assistance in Community Integration Services pilot jurisdiction (Cecil County) has SUD and experiences homelessness.

California's Whole Person Care pilot programs—created as part of the state's section 1115 demonstration—specifically target high-risk Medi-Cal beneficiaries, such as individuals with SUD, who are experiencing homelessness, have multiple chronic conditions, or are high ED utilizers. Thirteen of California's 25 Whole Person Care pilots focus on Medi-Cal beneficiaries with mental health and/or substance use diagnoses, and many target individuals with mental health disorder and/or SUD who are experiencing or are at risk of experiencing homelessness. Eighty-seven percent of Los Angeles County's Whole Person Care pilot participants meet the HUD definition of chronic homelessness.

Mercy Care, an integrated physical and behavioral health Medicaid managed care organization in Maricopa County, Arizona, targets high-cost, high-need Medicaid-eligible individuals who are experiencing or at risk of experiencing homelessness and who have an OUD/SUD and/or mental health disorder under its "Comprehensive Community Health Program." Philadelphia, Pennsylvania's Community Behavioral Health is the MCO contracted by Philadelphia's Department of Behavioral Health and Intellectual DisAbility Services to administer behavioral health and housing support services to Philadelphia County Medicaid beneficiaries with a mental health disorder and/or SUD who are experiencing homelessness. This is authorized under the state's section 1915(b)(1), (2), and (4) HealthChoices program. One of Community Behavioral Health's contracted providers—Pathways to Housing PA—specifically provides housing supports to individuals experiencing chronic homelessness who have an OUD/SUD.

d. Integrated Care Coordination Strategies

State programs have adopted integrated care coordination approaches focused on medical, behavioral health, and social support needs. These models include assessment and linkage services to expeditiously connect participants to primary care, mental health and/or SUD treatment and other needed services and recovery supports, as well as provide ongoing care coordination. States integrate individual housing transition services and tenancy sustaining services into these multidisciplinary care coordination models.

Yakima Neighborhood Health Services, an FQHC and an enrolled provider of the Foundational Community Supports program under Washington's section 1115 demonstration, administers a comprehensive integrated service delivery model. Case managers, outreach nurses, behavioral health service providers, housing specialists, employment specialists, and primary care providers (including doctors, advanced registered nurse practitioners, dentists, and pharmacists) share an integrated electronic health record system to coordinate service delivery for program participants. Many of California's Whole Person Care pilots assimilate housing navigation specialists and tenancy support specialists into interdisciplinary care coordination teams.[63]

e. Provider Outreach

State Medicaid programs and some Medicaid providers extend technical assistance to health and housing providers aimed at overcoming health and housing system language barriers, program process and implementation challenges and culture differences. The Maricopa County program offers training for community providers, hospitals, and behavioral health providers on the housing component of their model in response to concerns about participants transitioning into independent housing. Maryland hosted an outreach learning collaborative that included informing health departments and housing providers about Medicaid billing procedures. Yakima Neighborhood Health Services sponsors training on evidence-based practices to help build skills and support among the local community of providers. These provider training and technical assistance programs are supported through state-only, local, or grant funding.

f. Peer Supports

Four out of five of the states provide access to peer recovery support services furnished by individuals with lived experience of addiction and recovery. . The Maricopa County program employs peer navigators with lived experience of SUD and homelessness to conduct outreach and engagement activities. The Los Angeles County Whole Person Care pilot uses community health workers, many of whom have a personal history of SUD and who are in recovery, to engage individuals and to assist individuals with navigating the affordable housing system. Philadelphia's program offers Medicaid-covered Certified Peer Specialists to support individuals residing in supportive housing. Washington's Health Care Authority (state Medicaid agency) Peer Support Program trains and qualifies Medicaid-covered Certified Peer Supports to work with Foundational Community Supports participants living in supportive housing to promote recovery and wellness.

g. Coordinating Multiple Funding Sources

Although the five state programs cover an array of housing-related and recovery services and supports under their respective Medicaid programs, federal financial participation under section 1115 authority or section 1915 authority does not cover all of the services that may help an individual with SUD who is experiencing or is at risk of experiencing homelessness to achieve and maintain housing stability. Through section 1115 authority, California's Whole Person Care pilots may utilize a county-wide Flexible Housing Pool to structure funding to pay

for housing-related services and supports. The Flexible Housing Pool may include Whole Person Care pilot payments for housing-related deliverables for which federal financial participation is available. In addition, the Flexible Housing Pool may include funds that will be used for long-term housing costs, including rental subsidies that are not eligible for federal matching funds through the Whole Person Care pilots. Whole Person Care pilot entities may provide or collect contributions to the Flexible Housing Pool from partner agencies or from community entities.[64] Maryland's Assistance in Community Integration Services pilots leverage HUD and philanthropic resources to fund outreach and engagement for pilot participants. Washington coordinates the Substance Abuse and Mental Health Services Administration's (SAMHSA's) State Targeted Response to the Opioid Crisis grants, State Opioid Response grants, and Projects for Assistance in Transition from Homelessness funds, and other local resources to fund outreach and engagement.

h. Local Flexibility

Local stakeholders contribute to the design and implementation of state Medicaid programs targeted to assist individuals experiencing or at risk of experiencing homelessness. California's Whole Person Care pilot program provides an option to a county, a city and county, a health or hospital authority, or a consortium of any of the above entities to lead and coordinate programs to provide wraparound services to Medicaid-eligible individuals. While the state establishes minimum standards for participation, lead entities have flexibility to propose strategies that would best meet the needs of their local communities. Maryland's Assistance in Community Integration Services pilot application must be completed by a lead local government entity agreeing to provide leadership and coordinate with key community partners to deliver the programs. Washington formed regional Accountable Communities of Health, supported in part by the State Innovation Models (SIM) initiative under the Center for Medicare & Medicaid Innovation (the CMS Innovation Center),[65] bringing together public and private entities to form multisector partnerships that work on shared health goals. Accountable Communities of Health are responsible for guiding clinical and community linkages, including those impacting housing stability. Pennsylvania's Medicaid agency contracts with managed care plans to provide physical health services for Medicaid-eligible individuals while giving counties (Philadelphia County) flexibility to manage behavioral health services. Similarly, Arizona's Medicaid agency contracts with managed care plans to provide behavioral health services at a regional level. The approach

in Pennsylvania and Arizona grants MCOs flexibility to design and implement programs to address needs specific to a community.

i. Payment Models

States test various payment models for the coverage of housing-related supports. Some of the interviewed programs reimburse for discrete housing-related services and others bundle housing-related services with other supports. California's Whole Person Care pilot lead entities have the flexibility to choose financing structures best suited to their respective local communities that may include fee for service (FFS), per member per month (PMPM) bundles, pay for reporting, pay for outcomes, and incentive-based payments. Most Whole Person Care pilots are using PMPM bundles to pay for care coordination and housing-related services and supports.[66] The Maryland Assistance in Community Integration Services program established a set of discrete "tenancy-based case management services/tenancy support services" and "housing case management services." Providers receive a PMPM reimbursement for delivering a minimum of three of the approved pre-tenancy or tenancy support services.[67] Washington contracts with a third-party administrator using a combination of FFS and PMPM payments based on the number of beneficiaries enrolled in the program.[68]

Value-based payment models are being tested by several of the programs interviewed for this report that adopt strategies to address quality, cost, and outcomes in the delivery of housing-related services and supports. In Maricopa County, Mercy Care is implementing a pay for performance model based on improving housing retention, decreasing inpatient utilization, decreasing crisis utilization, and increasing health care visits.[69] The Philadelphia program is exploring a value-based payment model to reimburse providers for housing-related services. Journey of Hope, a provider of housing-related services under Philadelphia's program, receives annual performance payments for meeting measures of stable transitions to permanent supportive housing, independent living, recovery housing, or other community living settings such as residing with family/friends.[70]

Several of the programs offer incentive payments to providers. The two managed care programs (Maricopa County and Philadelphia) provide payment incentives for meeting benchmarks for certain metrics, including a measure of housing retention. As part of the Placer County Whole Person Care team, the Placer County Housing Authority receives pay-for-reporting funding for semi-annual and annual reporting on housing data for the Whole Person

Care pilot. Additionally, the Placer County Whole Person Care program is implementing a pay for reporting incentive for the timely submission of all necessary program reporting required by the state.[71]

j. Data Strategies

States and programs interviewed for this report deployed multiple data strategies and information technology approaches to identify program participants, to enhance care coordination, to determine service needs, and to evaluate program outcomes.

Under California's section 1115 demonstration, Whole Person Care pilots are required to demonstrate increased care coordination, increased access to social services, improved housing stability (if applicable), improved health outcomes, and reductions in avoidable use of emergency and inpatient services, among other measures.[72] The Placer County Whole Person Care pilot implemented a data sharing strategy with hospitals, EDs, and other Whole Person Care providers to identify Whole Person Care members in need of care coordination and referrals. [73] The Los Angeles County Whole Person Care pilot is building a data-sharing network sensitive to health information privacy regulations. The Marin County Whole Person Care pilot is developing an integrated information system between four community health centers, Marin General Hospital, emergency medical services, county behavioral health and crisis services, detention health services, and the Medi-Cal managed health plan to improve health and housing outcomes for individuals experiencing or at risk of experiencing homelessness.[74]

Some states and communities are using screening tools or algorithms that assess vulnerability and risk among individuals experiencing homelessness to prioritize access to housing assistance and services for those with the greatest need.[75] Washington developed a risk stratification tool using its integrated client database based on Medicaid health care expenditures. The Predictive Risk Intelligence System (PRISM) stratifies or scores by acuity risk. The state uses this system, requiring a risk score of 1.5 or greater, as one of the qualifications to enroll in the Foundational Community Supports program. The state also uses PRISM and multiple other systems to inform modeling that helps ascertain effects of supportive housing on those in multiple systems. Under California's section 1115 demonstration, some Whole Person Care programs have developed systems to integrate homelessness management information system (HMIS) data with county data systems and electronic health records. The Contra Costa Whole Person Care pilot has a data warehouse that now includes data on whether an individual has

accessed any homeless program in the past 15 years and a measure that indicates whether that person is currently homeless. In the future, homelessness management information system data available in the electronic health record will include housing programs the patient is actively engaged with and contact information.[76]

Data sharing can be key to integrating care and meeting other programmatic needs. Community Behavioral Health, the Philadelphia MCO, is required to establish coordination agreements necessary to collect data elements from providers, members, and other community-based entities using integrated data systems, data warehousing, and analytic report functionality.[77] Community Behavioral Health created integrated care teams that share medical and pharmacy data with physical health providers, working to generate joint plans for high-risk enrollees and to flag individuals who are experiencing homelessness. Taking a "no wrong door" approach, the MCO integrated its care coordination activities into all public health clinics and FQHCs, including satellite clinics. This expansive approach was useful as Community Behavioral Health worked with housing providers to help those displaced from Philadelphia's homeless encampments.[78]

States adopt varying approaches to measuring housing outcomes. California's Whole Person Care section 1115 demonstration encourages flexibility to address local needs. As such, the state requires Whole Person Care pilots to collect semiannual universal and variant metrics, including process and outcome measures, with annual target benchmarks. The Los Angeles County Whole Person Care pilot adopted five variants, one of which is specific to housing: proportion of clients housed by the Whole Person Care program who are permanently housed for more than 6 months.[79] The Placer County Whole Person Care pilot collects data on two housing metrics: (1) percentage of homeless participants receiving housing services that were referred for housing services and (2) percentage of enrolled Whole Person Care members who receive medical respite program services and show improvement in their physical health condition at the time of discharge.[80]

In contrast, Washington is collecting metrics on the statewide Foundational Community Supports program to inform system transformation. Metrics focus on whether the provision of foundational community supports—supportive housing and supported employment—will improve health outcomes and reduce costs for a targeted subset of Medicaid-eligible individuals. Among the state-defined measures is a rate of homelessness.[81] Yakima Neighborhood Health

Services, a Health Care for the Homeless FQHC, has the capability to share HMIS data with electronic health records, allowing the FQHC to identify individuals experiencing homelessness with co-occurring disorders and receipt of primary care services. The FQHC is working to consolidate SAMHSA's Performance Accountability and Reporting System data to enable it to report on the extent of depression and substance use screening and substance use treatment participation for Foundational Community Supports participants. These capabilities help the FQHC to meet the state's reporting requirements and to identify population health needs.[82]

IV. Strategies Employed by Medicaid Managed Care Organizations, Primary Care Case Managers, Hospitals, Accountable Care Organizations, and Other Care Coordination Providers to Deliver Housing-Related Services and Supports and to Coordinate Services Provided under State Medicaid Programs across Different Treatment Settings (SUPPORT Act, Section 1017(b)(2))

Hospitals, accountable care organizations (ACOs), MCOs, and other care coordination providers appear to be particularly focused on expanding services to holistically improve health outcomes for high-need, high-cost Medicaid-eligible individuals, while averting unnecessary costs to health care and public systems. As research cited in this report has demonstrated, 5 percent of Medicaid-eligible individuals account for more than 50 percent of program costs. Individuals with SUD who are experiencing or are at risk of experiencing homelessness are highly represented in this high-cost Medicaid population group.[83] This section of the report highlights strategies employed by the above-mentioned types of health care entities to deliver housing-related services and supports to improve individual health outcomes and reduce health care costs. For the purposes of section 1017(b)(2), CMS was not able to obtain information on primary care case management organizations (PCCMs) targeted to individuals with SUD experiencing or at risk of experiencing homelessness. However, case management services, including those furnished by primary care case managers, are an important component of many of the programs discussed in this and other sections.

a. Medicaid Managed Care Organizations

Nationwide, the majority of Medicaid-covered individuals are enrolled in managed care for some or all of their health care services, including individuals with high health care utilization and individuals with complex social needs.[84] Some Medicaid managed care organizations are working with states on strategies to address housing stability needs for Medicaid-eligible individuals who are at high risk and have historically high need and utilization patterns.

Massachusetts' Community Support Program for Persons Experiencing Chronic Homelessness is a partnership between the Massachusetts Housing and Shelter Alliance and the Massachusetts Behavioral Health Partnership, the state's behavioral health managed care contractor that provides Medicaid-reimbursed community support services to people with mental

health disorders, and often a co-occurring SUD, who are experiencing chronic homelessness. Massachusetts Behavioral Health Partnership leveraged state support for a creative and flexible solution to homelessness. Massachusetts Behavioral Health Partnership brokered local strategic partnerships between behavioral health providers in the MCO's network and non-network housing providers that have available housing vouchers. Massachusetts Behavioral Health Partnership offered outreach, service coordination, assistance with obtaining housing, and wraparound supports that have lowered costs and improved individual level outcomes.[85] This program started as a pilot in Boston and was expanded statewide under Massachusetts's section 1115 demonstration.[86]

Hennepin Health is a county-administered MCO in Minnesota that integrates care across medical, behavioral health and human services, and addresses social determinants of health,[87] including housing, as a strategy for improving health outcomes and lowering costs for the most complex and highest cost Medicaid enrollees. Recognizing the link between housing instability and high health care utilization, Hennepin Health now implements housing navigation services focused on finding housing for homeless members or those with unstable housing. Housing navigators work with the clinical care coordination staff to locate housing that meets members' needs, and a partnership with the Minnesota Public Housing Agency and others helps to identify housing options.[88]

Arizona's state Medicaid agency, the Arizona Health Care Cost Containment System, has a 10-year history of coordinating state and local funding to provide supportive housing for Medicaid-eligible individuals who are experiencing homelessness. In response to the homeless crisis in downtown Phoenix, the Arizona Health Care Cost Containment System launched a plan with Mercy Care MCO and Community Bridges Inc. (a service provider) to house 100 individuals experiencing homelessness from downtown Phoenix. Mercy Care created a partnership with three public housing authorities to set aside rental assistance vouchers for the 100 individuals. The Arizona Health Care Cost Containment System is providing state-only rental assistance funding for program participants for up to 24 months while participants wait for the availability of a federally funded rental assistance voucher from one of the partnering public housing authorities. Mercy Care coordinates Medicaid-covered supportive services to help the individuals find housing and achieve independent community living goals.[89]

b. Hospitals

State programs coordinate with hospitals on strategies to assist individuals who are experiencing homelessness to gain access to Medicaid-covered services and non-Medicaid-covered services. Some hospitals fund non-Medicaid-covered short-term housing referred to as "medical respite" programs or "recuperative care," which refers to short-term inpatient care for people experiencing homelessness who are too sick to recover on the streets or in a shelter but are not sick enough to continue staying in a hospital.[90,91] Local hospitals in Maricopa County, Arizona, in partnership with FQHCs, fund medical respite programs. Arizona recently participated in the Health Care Innovation Awards (Round Two) awarded by the CMS Innovation Center to the National Health Care for the Homeless Council (NHCHC) to test a model providing medical respite care for homeless Medicare and Medicaid beneficiaries following discharge from a hospital with the goal of improving health, reduce readmissions, and reduce costs.[92] Medical respite is also offered under the Santa Clara County Whole Person Care Pilot program.[93] "The Santa Clara County Medical Respite Program is a collaborative program between the Hospital Council of Northern & Central California (and the eight participating hospitals in the county it represents), a local shelter provider (EHC Lifebuilders), and the Valley Homeless Healthcare Program which operates the program on a day-to-day basis. The planning for the Medical Respite Program was coordinated by the Hospital Council during a county-wide initiative to end homelessness."[94]

Some hospitals also partner with state programs to help connect individuals with a mental health disorder and/or SUD experiencing homelessness to housing-related services. The Los Angeles County Whole Person Care pilot places housing navigators in local hospitals to identify program participants and to begin the process of linking individuals with a MH/SUD to housing resources. The Placer County Whole Person Care pilot implemented a data sharing strategy with hospitals, EDs, and other Whole Person Care providers to identify Whole Person Care members in need of care coordination and referrals.[95]

Finally, the Camden Coalition Medicaid ACO in Camden, New Jersey, and two local hospitals developed an arrangement, described below, whereby the Coalition receives an email of a daily list of patients currently in the hospital with two or more inpatient admissions and/or six or more ED visits in the last 6 months. The Coalition team reviews the daily admissions to identify potential participants for their integrated care coordination program.[96]

c. Accountable Care Organizations (ACOs)

Medicaid ACOs adopt strategies to improve integrated care coordination for Medicaid-eligible individuals. The Camden Coalition, a Medicaid ACO, uses "healthcare hot spotting"[97] to identify individuals with frequent hospital use and complex health and social needs. Individuals are referred to community-based care teams comprised of nurses, social workers, and community health workers. The Camden Coalition administers a Housing First pilot program for individuals experiencing homelessness that provides rental assistance and optional wraparound support services. Among Housing First participants, at least 66 percent have a substance use diagnosis. Of those with a substance use diagnosis, at least 31 percent have an opioid-related diagnosis. Rental assistance for this program is not covered by federal financial participation.[98]

Massachusetts' State Medicaid agency, MassHealth, recently received approval from CMS to implement a Flexible Services Program through an existing section 1115 demonstration, beginning in January 2020 as a component of the state's Medicaid ACO program. Similar to Oregon's Coordinated Care Organizations, Massachusetts ACOs offer members "flexible services," which include non-medical services designed to address social needs.[99]

d. Care Coordination Providers

The programs interviewed for this report adopted integrated care coordination models focused on medical, behavioral health, and social support needs. These models include assessment and linkage activities to connect to primary care, mental health, SUD treatment, recovery support, and other needed services, in addition to providing ongoing care coordination.

Community Behavioral Health, the Philadelphia Medicaid MCO, employs integrated care teams that share medical and pharmacy data with physical health providers, working to generate joint plans for high-risk enrollees and to flag those who are homeless. The MCO has integrated its care coordination activities into all public health clinics and FQHCs, including satellite clinics. Mercy Care provides care coordination to access services such as transportation, crisis support, peer supports, mentoring, advocacy, and life skills, in addition to physical and behavioral health care, MAT, detoxification, supported employment, and supportive housing.

Under the Los Angeles County Whole Person Care pilot, a "Homeless Care Support Service" offers individuals intensive case management. Case managers, contracted under local homeless service provider organizations, assess and link individuals to needed primary care, mental health, and SUD treatment and provide ongoing care coordination. The Placer County

Whole Person Care pilot bundles payment for Comprehensive Complex Care Coordination for individuals experiencing homelessness. During a 12-month period, 86 percent of Placer County's Whole Person Care pilot participants received a Comprehensive Complex Care Coordination visit within 7 days of inpatient discharge and 92 percent within 7 days of an ED visit.[100]

Using a multidisciplinary approach, Yakima Neighborhood Health Services, an FQHC and an enrolled provider of the Washington Foundational Community Supports program, administers an integrated provider team model that includes primary care, medical respite, case managers, outreach nurses, behavioral health specialists, housing specialists, and employment specialists and uses an integrated electronic health record system to coordinate service delivery for Foundational Community Supports participants.

V. Innovative Strategies and Lessons Learned by States with Medicaid Waivers Approved under Section 1115 or 1915 of the Social Security Act (42 U.S.C. § 1315, 42 U.S.C. § 1396n) (SUPPORT Act, Section 1017(b)(3))

States seeking additional flexibility in the design of their Medicaid programs may apply for waivers of some statutory requirements or expenditure authority from the Secretary of the U.S. Department of Health and Human Services. For example, certain eligibility and benefit provisions of the Medicaid statute may be waived in order to explore new approaches to the delivery and payment of housing-related services and supports. States can use waivers to offer a specialized benefit package to a subset of Medicaid beneficiaries or to take actions such as restricting enrollees to a specific network of providers. States can also use expenditure authority available under section 1115(a)(2) to test housing-related supports or target populations that would not typically be eligible for federal financial participation.

Under section 1115 of the Social Security Act (the Act), the Secretary may approve any experimental, pilot, or demonstration project, that in the judgment of the Secretary, is likely to assist in promoting the objectives of certain programs under the Act, including Medicaid. Section 1115(a)(1) of the Act allows the Secretary to waive compliance with the Medicaid requirements of section 1902 of the Act, to the extent and for the period he finds necessary to carry out the demonstration project. In addition, section 1115(a)(2) of the Act allows the Secretary to provide federal financial participation for demonstration costs that would not otherwise be considered as federally matchable expenditures under section 1903 of the Act, to the extent and for the period prescribed by the Secretary.[101] States may also receive home and community-based services (HCBS) waivers under several different provisions in section 1915 of the Social Security Act. Operating within broad federal guidelines, these HCBS authorities generally allow states to meet the needs of people who prefer to get long-term care services and supports in their home or community, rather than in an institutional setting.

The ability to waive certain provisions of the Medicaid statute gives states flexibility to experiment with different approaches to addressing the health care needs of individuals with SUD who are experiencing or are at risk of experiencing homelessness through program operation, service delivery, and payment. Below we describe the statutory framework for section 1915(b), section 1915(c), section 1915(i), and section 1115 authorities and indicate the innovative strategies and lessons learned from programs implemented under them.

a. Innovative Strategies under Section 1115 and Section 1915 of the Act

To gain insight into innovative strategies and lessons learned by states with Medicaid demonstrations or waiver programs approved under section 1115 or section 1915 of the Act, interviews were conducted with staff from three states and two county-level programs (California; Maryland; Washington; Maricopa County, Arizona; and City/County of Philadelphia) offering Medicaid coverage of housing-related services and supports to individuals who are experiencing or are at risk of experiencing homelessness. Individuals with SUD are highly represented in these selected programs. These programs have been discussed in detail in section III of this report. Other programs are also mentioned, and in most of these programs, published information and data come from program evaluations.

States are increasingly testing, evaluating, and advancing best practices around providing housing-related and recovery services and supports for Medicaid-eligible individuals with SUD who are experiencing or at risk of experiencing homelessness. States are collaborating across health, housing, and social systems to coordinate and integrate care, services, and funding resources to foster the successful development of Medicaid programs to meet needs specific to a community.

Section 1915(c) HCBS waiver programs offer states flexibility to test new ways to deliver care as well as give states the option to target populations in a specific geographical area; however, few states choose the section 1915(c) HCBS waiver program authority to cover housing-related services for individuals experiencing homelessness. One limiting factor is that services are restricted to Medicaid-eligible individuals who meet the state's criteria for needing an institutional level of care (LOC). Many individuals with SUD who are experiencing or at risk of experiencing homelessness have complex medical conditions; however, they may not meet the state's eligibility requirements for services in a medical institution. In contrast, Medicaid-eligible individuals with needs that are not intensive enough to meet the state's level of care criteria may qualify for section 1915(i) state plan HCBS, which must be offered statewide, provided that the individuals meet certain needs-based criteria. Needs-based criteria are factors used to determine an individual's requirements for support that can only be ascertained for a given person through an individualized evaluation of need and may include but cannot only include state-defined risk factors, such as risk of or experiencing homelessness.

States have indicated some interest in covering housing-related services under section 1915(i) state plan HCBS but have encountered issues around defining eligibility to create highly targeted programs serving individuals who are experiencing or are at risk of experiencing homelessness. Under section 1915(i) state plan HCBS, the statute defines eligible individuals as those who are eligible for medical assistance under the state plan, meet state-defined needs-based criteria, and reside in the community. Section 1915(i) state plan HCBS also offers states the option to target the benefit to a specific population based on age, disability, diagnosis, and/or Medicaid eligibility group. Needs-based criteria may include state-defined risk factors, including risk of or experiencing homelessness. However, eligibility for the section 1915(i) state plan benefit must include criteria on level of functionality and may not be determined using only risk factors.

Louisiana includes tenancy supports in several section 1915(c) HCBS waiver programs for individuals who are aged, with physical disabilities and with intellectual and developmental disabilities (I/DD) as part of the state's permanent supportive housing program. Louisiana's permanent supportive housing program serves a cross-disability population that includes individuals with I/DD, as well as individuals with mental health disorders who are experiencing homelessness or at risk of experiencing homelessness. Individuals with a co-occurring diagnosis of SUD and a mental health disorder, although not a target population, are represented. The Louisiana state plan covers an array of rehabilitative services, such as individual and group therapy, crisis intervention, medication management, and withdrawal management that assist in restoring individuals with SUD and mental health disorders to their best possible functioning level in the community. Louisiana reports a 94 percent housing retention rate and statistically significant reductions in hospitalizations and ED utilization for program participants.[102,103]

A common theme for many states is exercising the flexibility under section 1115 authority to test new approaches to providing Medicaid coverage of housing-related and recovery services and supports for Medicaid-eligible individuals with SUD who are experiencing or at risk of experiencing homelessness. Many of these approaches and strategies have been discussed in detail in section III of this report. Furthermore, more detailed information on section 1115 demonstrations and other Medicaid authorities can be found in section VI of this report. The goals for innovations under these demonstrations often begin with multiple aims: "achieve more effective and efficient health systems; improve health outcomes while reducing costs; and

strengthen linkages and partnerships to community-based resources that alleviate the effects of social determinants of health."[104]

To help meet these broad goals, four out of five states interviewed for this report are testing housing-related services and supports under section 1115 demonstrations by adopting targeting, partnership, and operational strategies such as including homelessness or at risk of homelessness as one of the risk-based criteria for service eligibility in addition to other functional eligibility criteria; piloting programs in specific geographic areas; partnering with Medicaid MCOs; and using data and technology to enhance care coordination and community linkages. In addition to California, Washington, Maryland, and Arizona, several other states have recently pursued these same strategies. Hawaii offers housing-related services to Medicaid-eligible individuals who meet specified needs-based criteria, such as having SUD and experiencing or at risk of experiencing homelessness under a section 1115 demonstration amendment approved by CMS on October 31, 2018. In July 2019, Florida and Illinois began piloting programs providing housing-related services and supports to individuals with significant behavioral health needs who are experiencing or are at risk of experiencing homelessness under section 1115 demonstration amendments in certain geographic areas. Hawaii, Florida, and Illinois will implement these programs in coordination with Medicaid MCOs.[105]

States routinely rely on section 1115 demonstration authority to authorize population and geographic targeting to limit coverage of housing-related services allowable under section 1915(c) HCBS waiver programs and section 1915(i) state plan amendment (SPA) authority. Under the above-mentioned demonstrations, states are covering HCBS activities allowable under section 1915(c) and section 1915(i) such as assessment of, and care plan development for, an individual's housing needs (including the identification of services not funded by Medicaid); provision of transitional services to establish community residency; tenancy sustaining services that provide skills to the individual on relationship building and community living; and linkages with other medical and non-medical services once in residence. States have exercised the flexibility under section 1115 demonstration authority to waive Medicaid requirements such as state-wideness and to more specifically target population groups for programs designed to address the needs of individuals with SUD who are experiencing or are at risk of experiencing homelessness.

With the focus on HCBS-like services under these demonstrations, states are implementing strategies to strengthen connections and linkages across clinical and non-medical community-based resources that support and enhance housing stability for Medicaid-eligible individuals with SUD who are experiencing or are at risk of experiencing homelessness. California's Whole Person Care pilots must commit to expanding their existing data sharing frameworks to improve communication and connections across health care providers, care coordinators, and social service providers. The MCO-administered programs emphasize integrated care coordination focused on medical, behavioral health, and social support needs, including assessment and linkage activities to connect to primary care, mental health and/or SUD treatment, and other needed services and recovery supports, as well as providing ongoing care coordination.

CMS identified limited use of section 1915(b)(3) waiver programs to deliver housing-related services targeted to individuals with SUD who are experiencing or are at risk of experiencing homelessness. Colorado's 1915(b)(3) HCBS waiver program, the Accountable Care Collaborative: Limited Managed Care Capitation Initiative, includes Assertive Community Treatment (ACT), provides comprehensive, locally based treatment to adults with mental health disorders. Colorado's ACT services are highly individualized and are available 24 hours a day, 7 days a week, and 365 days a year to clients who need significant assistance and support to overcome the barriers and obstacles that confront them. ACT teams provide case management, initial and ongoing behavioral health assessments, psychiatric services, employment and housing assistance, family support and education, and SUD services.[106]

b. Lessons Learned

The following are some lessons learned from the state programs reviewed for this report that are delivering housing-related services and supports to individuals with SUD who are experiencing or are at risk of experiencing homelessness under section 1915(b) waivers, section 1915(c) and section 1915(i) HCBS programs, and section 1115 demonstrations:

- States partnered with local public agencies, community-based organizations, and local MCOs to design programs to provide housing-related services to individuals with SUD experiencing or at risk of experiencing homelessness, allowing these entities to experiment with ways to more comprehensively meet the needs of their communities and to leverage local resources and partnerships.

- States integrated supportive housing into health care models and are experimenting with ways to increase Medicaid coverage of services and supports that are fundamental to supportive housing.
- States were committed to using health technology and data to improve care coordination and cross-agency collaborations in the delivery of housing-related services and supports. Investing in measurement and reporting helped to inform new state Medicaid reforms.
- States sought to strengthen connections across clinical and non-medical community-based resources that support and enhance housing stability and recovery.
- States designed housing-related services allowable under section 1915(c) HCBS waiver programs and/or 1915(i) HCBS state plan programs while using the population and geographic targeting flexibility authorized through the use of section 1115 demonstration projects.
- States primarily tested the delivery of housing-related services and supports under small-scale efforts through localized pilot programs in an effort to inform future scalability and alignment with state priorities and reform goals.
- States experimented with numerous approaches in the delivery of housing services, including payment models, hiring non-traditional health workers to furnish peer supports, and coordinating multiple funding streams to provide access to a full continuum of both Medicaid-covered services and non-Medicaid covered services.
- States recognized the value of bringing together providers and organizations from housing agencies, MCOs, hospitals, clinics, community behavioral health providers, social service organizations, and other community-based entities to create a multidisciplinary approach to helping individuals with SUD who are experiencing or are at risk of experiencing homelessness achieve housing stability.

c. Challenges Experienced by States in Designing, Securing, and Implementing Section 1115 Demonstrations and Section 1915 Waivers or Plan Amendments (SUPPORT Act, Section 1017(b)(3)(A))

In addition to the innovative program features noted earlier, interviews with states and review of program materials and literature identified challenges in the design, approval, and

implementation of delivering housing-related services for individuals with SUD experiencing or at risk of experiencing homelessness.

i. Design Challenges

States experience a common set of challenges in using existing flexibilities and waiver authority to design housing-related services for individuals with SUD who are experiencing or are at risk of experiencing homelessness. As noted in italics in the following discussion, these challenges range from the need to develop and strengthen partnerships at federal, state, and local levels to selecting the appropriate Medicaid authority for covering services for individuals with SUD who are experiencing or are at risk of experiencing homelessness.

A. *States must be willing to commit time and resources to engage key stakeholders from both the health and housing sectors in extensive planning processes to develop approaches to cover housing-related services in their Medicaid programs*. States interviewed recognized that access to affordable housing and the supports necessary to maintain housing is a cost-effective health intervention for individuals with SUD who are experiencing or at risk of experiencing homelessness. Therefore, states established workgroups, conducted housing and service needs assessments, and participated in technical assistance opportunities such as the Medicaid Innovation Accelerator Program (IAP)[107] to create a coordinated approach in the design of housing-related services and supports that meet the broad array of need for individuals experiencing or at risk of experiencing homelessness.

State opioid task forces (typically launched by the governor's office or attorney general's office) may be a specific venue where homelessness and housing stakeholders intersect with states' SUD and opioid strategies. For example, Ohio created an advisory council (Recovery Ohio Advisory Council) that was charged with developing a set of recommendations to improve mental health and substance use prevention, treatment, and recovery support services. Recommendations include *"A Housing Plan"* with nods to transitional housing, permanent supportive housing, supportive housing, and homelessness, in conjunction with goals to expand treatment such as residential treatment through waiver programs.[108] Washington's State Opioid Response Plan contains references to addressing housing needs, in addition to Medicaid-related components.[109] In addition, the section 1115 demonstration planning process includes a federally required state public comment period during which multiple stakeholders may be engaged, as well as a federal public comment period.

Although New York State was not interviewed for this report, substantial documentation of New York State's planning process for the design of its supportive housing program illustrates the effort that states are undertaking to design programs intended to increase access to supportive housing for Medicaid-eligible individuals with SUD experiencing or at risk of experiencing homelessness. New York established the Medicaid Redesign Team Supportive Housing Workgroup to bring together key stakeholders, including service providers, developers, advocates, and state agencies, to develop recommendations for increasing access to affordable and supportive housing. Some of these recommendations were informed by needs assessment studies to better understand who should be prioritized for new supportive housing units.[110]

Houston, Texas conducted a community needs assessment to determine the target population for supportive housing and what services should be covered through the Integrated Care for the Chronically Homeless program. The planning group also conducted a literature review and visited other programs with similar focus to understand best practices for providing integrated care in supportive housing. Once the delivery model was defined and providers were selected through a competitive bidding process, months of discussions took place among the selected providers to work out how to operationalize the program and coordinate with each other.[111]

California granted flexibility to local jurisdictions to design and implement Whole Person Care pilots. Los Angeles County Department of Health Services, lead entity for the Whole Person Care Pilot Los Angeles program, worked closely with an array of health and social service entities to develop the vision, design, and implementation plan for its Whole Person Care pilot. Health plans (e.g., L.A. Care, Health Net, and their delegated plans), community-based providers (e.g., Partners in Care, multiple homeless service providers), and community-based and non-profit organizations (e.g., Los Angeles Regional Re-entry Partnership) participated in more than 50 Whole Person Care work group meetings over a 2-month period.[112]

B. In selecting the appropriate Medicaid authority to cover housing-related services for individuals experiencing homelessness, multiple factors may influence the design and scope of the services. States have to consider factors such as target populations, provider capacity, geographic coverage, cost, and the role of managed care. Additionally, housing-related services are only one part of a comprehensive set of behavioral health and social supports for individuals with SUD who are experiencing or are at risk of experiencing homelessness. States interviewed

for this report looked at how multiple funding streams and Medicaid options fit into the design of a comprehensive array of services and supports that aim to help move systems towards more efficient, coordinated, and integrated care. As states determine the Medicaid authority that will best align with state priorities, goals, and resources to provide housing-related services, the federal-state partnership plays a key role.

States designing housing-related services for individuals experiencing homelessness under a section 1115 demonstration collaborate with CMS during the entire cycle of the demonstration—from design, application review, negotiations and approval, to implementation, monitoring, and evaluation. CMS works with states to determine whether other federal Medicaid authorities (e.g., section 1905(a), section 1915(c)) may be available, instead of or in combination with section 1115 authority, in order to meet state policy goals.[113] Most states with section 1115 demonstrations that deliver housing-related services offer services allowable under section 1915(c) HCBS waiver programs and 1915(i) state plan HCBS.

It is important to note that currently, CMS will not approve a demonstration project under section 1115 authority unless the project is expected to be budget neutral to the federal government. As noted by CMS in a 2018 State Medicaid Director letter, "To assess budget neutrality, CMS currently subjects each demonstration to a budget neutrality test, which results in limits that are placed on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration."[114]

ii. Implementation Challenges

A. States emphasized the lack of affordable housing as a key impediment to successfully implementing programs that cover housing-related services and supports. In many communities, federal, state, and local funding and the supply of housing stock to address the continuum of housing needs for low-income households is not sufficient. For instance, federal housing assistance is a limited resource that serves just one out of every four very low-income renter households.[115] To increase the supply of affordable housing opportunities, including for individuals with SUD who are experiencing or at risk of experiencing homelessness, states devote resources and attention to the development, sustainability, and strengthening of partnerships with local and state housing agencies while also addressing communication barriers

between housing and health systems. Mercy Maricopa invested in technical assistance to better understand the affordable housing system and extended this assistance to behavioral health providers within its network. Similarly, Maryland invested in a learning collaborative to help Assistance in Community Integration Services pilot jurisdictions pursue a better understanding of language differences and practices between housing providers, health departments, and other pilot stakeholders.

B. States identified challenges related to insufficient provider capacity and lack of experience with Medicaid billing procedures and program requirements. Washington enrolled supportive housing providers and community action agencies that had no prior Medicaid billing or documentation experience. New providers and community-based organizations also did not understand the Medicaid service delivery and managed care system. The state reported that time and resources were needed to reorient business practices to align with Medicaid requirements. Maryland reported similar challenges.

California and Maryland noted challenges with implementing programs at a pilot or local jurisdictional level. California identified its biggest challenge as the administrative complexity of setting up 25 Whole Person Care pilots, referring to them as "miniature Medicaid programs," each with its own unique funding and administrative structure. Maryland reported similar issues with granting program flexibility at a localized county level. Finalizing local funding and contracts required a lot of work, time, and discussion.

C. States reported that individuals experiencing homelessness often are not enrolled in Medicaid at the time of first contact and lengthy periods of engagement are often needed to build trust with individuals prior to Medicaid enrollment. States interviewed for this report coordinated other funding resources such as SAMHSA grants and Health Resources and Services Administration grant programs to cover the costs of outreach and engagement.

D. States reported multiple data implementation challenges. States faced significant challenges in developing data sharing agreements such as Memorandums of Understanding (MOU). MOUs support partnerships between health and housing systems, facilitate needs assessments, and can document justifications for current or future data sharing needs.[116] Matching data from HMIS systems with Medicaid systems was also resource intensive and often was not technically feasible. Meeting privacy regulations to ensure that data sharing practices meet requirements under the Health Insurance Portability and Accountability Act of 1996, Public

Law 104-191, and 42 CFR Part 2[117] confidentiality requirements regarding the disclosure and use of substance use disorder treatment records often delayed program implementation.

d. How States Developed Partnerships to Implement Waivers or State Plan Amendments (SUPPORT Act, Section 1017(b)(3)(B))

Numerous opportunities have been made available to states to develop and strengthen partnerships to address housing stability needs for individuals with SUD who are experiencing or are at risk of experiencing homelessness. The Money Follows the Person (MFP)[118] demonstration expanded infrastructure and administrative funding for participating states to develop partnership capacity between Medicaid agencies and state housing agencies. The Medicaid IAP[119] in collaboration with the U.S. Interagency Council on Homelessness (USICH), SAMHSA, and HUD offered several rounds of program and technical assistance to help states forge housing and health partnerships. The Center for Medicare and Medicaid Innovation has also offered support and resources to states to test and scale payment and delivery system reforms that have included partnership building opportunities between health and housing agencies under the State Innovation Models Initiative and under the Accountable Health Communities Model.[120] States have also had opportunities to partner with non-profit hospitals to take advantage of a new provision in the Patient Protection and Affordable Care Act of 2010 requiring all non-profit hospitals to conduct a community health needs assessment and to develop strategies and identify resources to address significant health needs of the community.[121] Non-profit hospital activities have included addressing the community housing needs of high-cost, high-need individuals.[122] Additionally, as states are increasingly enrolling Medicaid-eligible individuals who are experiencing homelessness into managed care plans, states are actively engaging MCOs as partners to implement solutions for increasing housing stability for Medicaid beneficiaries.

Washington vigorously pursued participation in health reform initiatives to help shape a partnership model for advancing the state's population health transformation goals. The state applied for and received a State Innovation Model grant that led to the formation of nine regional Accountable Communities of Health serving as a regional multi-sector partnership to respond to local population and health care delivery needs while addressing social determinants of health. To specifically address housing partnership capacity within the regional Accountable Communities of Health, the state leveraged learnings from participation in the Chronic Homeless

Policy Academy, the Money Follows the Person demonstration, and national technical assistance received through SAMHSA and HUD to further develop the strategic planning processes and strengthen relationships and agreements with state and local housing and community development organizations.[123] These activities contributed to the design of the Foundational Community Supports Benefit under the state's current section 1115 demonstration, which offers housing and employment supports targeted to high-need, high-cost Medicaid-eligible individuals, including individuals experiencing or at risk of experiencing homelessness.

Several states have built partnership capacity by demonstrating success working on smaller initiatives and then integrating learnings and established partnerships into broader delivery system reform efforts. The success of Washington's Money Follows the Person demonstration around pursuing cross-sector collaborations and leveraging community resources to help individuals transition from medical institutions to the community helped to inform the state's adoption of a broader delivery system reform effort to further test housing supports under a section 1115 demonstration.

Some states are using broad reform efforts to build partnership capacity under local pilot programs. Under California's Whole Person Care program, the goal is to increase integration among county agencies, health plans, providers, and other entities within the county that serve high-risk, high-utilizing beneficiaries and to develop infrastructure to ensure collaboration among the participating entities over the long term. Whole Person Care pilots are required to include at least one MCO as a partner. Maryland's Assistance in Community Integration Services pilot application must be completed by a lead local government entity, such as a local health department or local management board. Lead entities are required to provide leadership and coordinate with key community partners to deliver the Assistance in Community Integration Services pilot program.

Other examples of building partnership capacity at a local level and building on success include Massachusetts' Community Support Program for Persons Experiencing Chronic Homelessness, the Houston Integrated Care for the Chronically Homeless Initiative, and the Camden Coalition. These programs target high-need, high-cost Medicaid-eligible individuals who are experiencing or are at risk of experiencing homelessness. In these examples, local community leaders in Boston, Massachusetts; Houston, Texas; and Camden, New Jersey,

coalesced community stakeholders to find solutions to widespread homelessness and frequent rates of ED utilization in their respective cities.

The Community Support Program for Persons Experiencing Chronic Homelessness is a partnership between the Massachusetts Housing and Shelter Alliance and Massachusetts Behavioral Health Partnership (the state's private behavioral health MCO) that provides Medicaid-reimbursed community support services to people with mental health disorders and often a co-occurring SUD who are experiencing chronic homelessness. Local partnerships of behavioral health and housing providers offer outreach, service coordination, assistance obtaining housing, and wraparound supports. This program started as a pilot in Boston and was expanded statewide under Massachusetts's Medicaid section 1115 demonstration.[124]

Under Texas's section 1115 Health Care and Quality Improvement Transformation demonstration, the Houston Integrated Care for the Chronically Homeless Initiative created a collaboration consisting of an FQHC, a homeless services provider, and a permanent supportive housing provider, targeting individuals who are experiencing chronic homelessness and are frequent users of hospital emergency services. The state is now considering piloting Houston's integrated care model throughout the state.[125]

The Camden Coalition is a New Jersey hospital-led partnership to integrate housing and health for frequent users of EDs by providing connections to social services, including supportive housing for people experiencing chronic homelessness. The Camden Coalition's early success led the state to establish Medicaid ACOs in Camden, Newark, and Trenton, based on the expectations of shared savings to Medicaid by reducing unnecessary ED visits through improved access to preventive care, affordable housing, and other social services.

Some MCOs have initiated collaborations to improve health outcomes and lower health care costs. As the health plan that serves as the Regional Behavioral Health Authority for Maricopa County, Mercy Care worked with the state of Arizona to implement a whole person care model for Medicaid-eligible individuals with SUD experiencing or at risk of experiencing homelessness. Mercy Care worked with community partners such as United Way and the City of Phoenix to secure housing subsidies and other resources that Medicaid does not cover to provide access to affordable housing opportunities. Mercy Care involved the local behavioral health provider community in the planning process and other community-based organizations to develop and support a comprehensive model offering case management, transportation, crisis

support, affordable housing subsidies, counseling services, and life skills in addition to SUD treatment services.

e. How and Whether States Plan to Provide Medicaid Coverage for Housing-Related Services and Supports in the Future, Including by Covering Such Services and Supports under State Medicaid Plans or Waivers (SUPPORT Act, Section 1017(b)(3)(C))

States are continuing to test housing-related services and supports targeted to high-cost, high need Medicaid-eligible individuals through demonstration projects authorized under section 1115 of the Act. Some states are expanding existing housing-related services under current demonstrations. Other states are showing interest in the Medicaid section 1945 health home option, and limited, but growing, interest in the section 1915(i) authority.

Under California's 2019-2020 Governor's Budget, the state is investing $100 million of state general funds for Whole Person Care pilot programs that provide housing services through section 1115 authority. Through an application process, pilots must demonstrate how this funding will complement the pilots' existing housing services and will not supplant existing funding.[126] In July 2018, Maryland submitted a section 1115 demonstration amendment requesting an additional 300 participant places for the Assistance in Community Integration Services pilot, bringing the total cap to 600 individuals annually. CMS approved this expansion in April 2019.[127]

Several states have recently received approval from CMS to implement housing-related services under section 1115 authority. In two distinct regions of the state, Florida is piloting supportive housing assistance services for persons aged 21 and older with serious mental illness, SUD, or serious mental illness with co-occurring SUD who are homeless or at risk of homelessness due to their disability. The pilot offers transitional housing support services, tenancy sustaining services, mobile crisis management, and peer support.[128] Hawaii is offering community integration services to Medicaid-eligible individuals who meet specified needs-based criteria, such as having a mental health need, SUD, or complex physical health need and who are homeless or at risk for homelessness.[129] Illinois is piloting a set of HCBS including pre-tenancy and tenancy sustaining services to individuals with high behavioral health needs who are experiencing homelessness or are at risk of experiencing homelessness.[130] New Mexico is piloting a program to assist individuals with serious mental illness in acquiring and maintaining

stable housing by providing pre-tenancy and tenancy supports.[131] Virginia is testing a set of HCBS including individual housing and pre-tenancy sustaining services and community transition services targeted to individuals with high needs that may include individuals with an SUD who are experiencing or are at risk of experiencing homelessness.[132]

Under section 1115 authority, states are required to conduct monitoring and evaluation of their programs' implementation. The section 1115 demonstrations covering housing-related services and supports targeted to individuals experiencing or at risk of experiencing homelessness are too early in the program implementation stage to share independent evaluation information on best practices and ultimately determine whether the demonstrations are achieving expected outcomes.

Section 2703 of the Affordable Care Act (ACA) (section 1945 of the Act) created an optional Medicaid State Plan benefit for states to establish Health Homes to coordinate care for people with Medicaid who have chronic conditions. The Medicaid health home option, which was first available to states in 2011, provides enhanced integration and coordination of primary, acute, behavioral health and long-term services and supports for people with chronic illnesses. Health home services include comprehensive care management, care coordination, health promotion, comprehensive transitional care from inpatient to other settings, patient and family support and referral to community and social support services. As of November 2019, 20 states and the District of Columbia have a total of 35 approved health home models.[133] A number of these health home programs provide assistance with housing resources for Medicaid beneficiaries. For instance, both Maine and Michigan operate a health home targeted to individuals with SUD in which the health home provides referrals to housing resources, as needed. In Michigan, care coordination services, which are provided by peer recovery coaches, "support each beneficiary to fully participate in communities of their choosing in the environment most supportive of their recovery and that promotes housing of their choice to build recovery connections and supports."[134] In Maine, health home providers conduct a clinical, comprehensive assessment of the beneficiary's needs including issues regarding housing. As part of care coordination services, the health home provides assistance to access and maintain safe, affordable housing.[135] California's health home targets individuals with chronic physical conditions and/or SUD, including individuals experiencing or at risk of experiencing homelessness. California's health homes provide comprehensive care management services that

include referrals between the health home providers and housing agencies and permanent housing providers, including supportive housing providers. In addition, health home providers partner with housing agencies to offer the members permanent, independent housing options.

Several states are considering using a section 1915(i) state plan HCBS benefit to cover housing-related supports and services. Connecticut's fiscal year (FY) 2020 – FY 2021 biennium state budget includes a proposal to implement a Medicaid Supportive Housing Benefit for High Cost, High Need Individuals based on a data-driven target strategy that has identified a high percentage of individuals with SUD who are experiencing homelessness as part of this population.[136]

The North Dakota state legislature recently approved funding to expand community-based recovery supports for Medicaid-eligible individuals with a behavioral health condition and/or brain injury and experiencing one or more of the following: housing instability, intensive service utilization such as frequent ED visits, and/or criminal justice involvement.[137]

Furthermore, Minnesota was approved for a section 1915(i) HCBS SPA that includes coverage of housing-related services. Minnesota's section 1915(i) SPA (SPA 18-0008) was approved with an effective date of July 1, 2020, covers housing stabilization services for individuals with disabilities who are experiencing or at risk of experiencing homelessness and individuals with a disability with MH/SUD who are living in institutions or other segregated settings or are at risk of living in those settings.

VI. Existing Opportunities for States to Provide Housing-Related Services and Supports through Various Medicaid Authorities (SUPPORT Act, Section 1017(b)(4))

Stable housing plays a vital role in the recovery process for individuals with SUD who are experiencing or at risk of experiencing homelessness. Stable housing provides a platform from which individuals can engage effective treatment programs that combine mental health and substance use treatment services with other recovery supports, including housing, childcare, vocational supports, educational services, legal services, and financial assistance.[138] The Medicaid program can offer a variety of flexible delivery approaches, benefits, and reimbursement methodologies to assist states with supporting individuals with SUD to achieve and maintain housing stability, which can have a positive impact on health and wellness outcomes, service utilization, and program costs.

Federal financial participation is not available to state Medicaid programs for room and board (except in certain medical institutions).[139] However, federal financial participation is available under certain federal authorities for housing-related supports and services that promote health and community integration. Authorities found in sections 1905(a), 1915(b), 1915(c), 1915(i), 1915(k), and 1115 of the Act are discussed in the following section.

State interest in the coverage of housing-related services and supports began to expand after the Supreme Court's *Olmstead decision* in which the Supreme Court interpreted Title II of the Americans with Disabilities Act and its implementing regulation to oblige states to administer their services, programs, and activities "in the most integrated setting appropriate to the needs of qualified individuals with disabilities" (28 CFR 35.130(d)). CMS recognized the important role that Medicaid plays in states' efforts to ensure compliance with the Americans with Disabilities Act and *Olmstead*. Between 1998 and 2001, CMS (then the Health Care Financing Administration) issued a series of letters to state Medicaid directors to identify policies, tools, and expectations for HCBS, along with describing how these services could be used by states in *Olmstead* compliance. These letters, collectively known as the "*Olmstead letters"*[140] identified services that help transition individuals from institutional to community settings and maintain their community living status.

The provision of housing-related services has assisted states in addressing the needs of individuals requiring LTSS to maintain their independence and foster community integration. More recently, many individuals who are experiencing homelessness have become eligible for

Medicaid as a result of Medicaid expansion,[141] increasing the need for state Medicaid programs to furnish covered services for individuals with mental health disorder and/or SUD, including housing-related and recovery services and supports. While there may be some variation in the delivery of housing-related services for different Medicaid eligible populations, the activities that comprise housing-related services tend to be consistent across populations. Activities such as assessment of, and care plan development for, an individual's medical and housing needs assists an individual with achieving community integration goals. The person-centered care plan may include the identification of services not funded by Medicaid and specify the need for the provision of transitional services to establish community residency and tenancy sustaining services that provide skills to the individual on relationship building and community living. Further linkages with other medical and non-medical services once in residence can be effective tools for states to offer across populations and provider types.

Moreover, Medicaid has played a crucial role in states' efforts to provide and expand HCBS for older adults, people with disabilities, and individuals with significant behavioral health and chronic illnesses, including individuals with SUD who are experiencing homelessness. CMS has extended flexibility to states to design a comprehensive array of services under different authorities that acknowledge the social determinants of health and contribute to a holistic focus on improvement of individual health and wellness. CMS also recognizes that, for those living with SUD, recovery is often a non-linear process that increases the need for robust, community-based systems that support recovery and community integration to meet individuals' care needs in non-institutional, community-based settings.

States can use several different federal authorities to cover services that may assist an individual with SUD who is experiencing homelessness or at risk for homelessness with gaining access to and maintaining housing as well as optimizing community integration.

a. Section 1905(a) State Plan Authority

Experiencing homelessness or having SUD does not equate to a determination of Medicaid eligibility or medical necessity for receipt of specific 1905(a) services, but once an individual is determined to be eligible, the state can provide mandatory or optional Medicaid services to meet an individual's health care needs.

The following are examples of state plan services that can help Medicaid-eligible individuals with SUD who are experiencing homelessness or at risk of experiencing

homelessness maintain independent community living. In the absence of a waiver, Medicaid requirements such as state-wideness, comparability, and freedom of choice of provider[142] must be met. State plan services can assist Medicaid-eligible individuals to transition to community-based settings and to gain access to needed medical and social services. Some state plan services can also directly assist individuals in the community and help them remain in their homes.

i. Rehabilitative Services Benefit

Rehabilitative services are authorized at section 1905(a)(13) of the Act and codified in regulation at 42 CFR 440.130(d) as "medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level." For example, states have covered rehabilitative services such as physical, occupational, and speech and audiology therapies, as well as mental health and SUD treatment services such as individual and group therapy, peer support services, ACT, and MAT.

Rehabilitative services may include services to help eligible individuals regain skills and functioning necessary to secure and maintain community-based housing. Individuals with SUD who have experienced prolonged episodes of homelessness may need help with restoring social interaction behaviors and problem solving. These skills are necessary when navigating the complexity of finding housing, filling out paperwork, securing identification, negotiating with landlords, paying bills, and interacting with neighbors.

Rehabilitative services may include services furnished by peers. Peer supports are effective at reaching individuals with SUD who are experiencing homelessness or are at risk of experiencing homelessness because peer support specialists are self-identified individuals with mental health disorder and/or SUD and may be more easily trusted by individuals with SUD who are experiencing homelessness. Peer support services can also include coordinating care and social supports and services for this population. CMS published a State Medicaid Directors Letter (SMDL #07-011)[143] in 2007 providing policy guidance on supervision requirements, care coordination, and minimum training criteria for peer support providers. In addition to section 1905(a)(13) rehabilitative services, states may choose to deliver peer support services through section 1915(b) and 1915(c) HCBS waiver programs and under section 1115 authority.

Assertive Community Treatment (ACT) is designed to help individuals live in the community and has consistently been associated with improving housing stability for individuals experiencing chronic homelessness with a mental health disorder and/or SUD. ACT has been furnished in concert with a Housing First approach.[144] ACT provides personalized community care by multidisciplinary teams. CMS published a State Medicaid Directors Letter (SMD060799b) on mental health services in 1999, listing the key elements of ACT as shared caseloads, 24-hour mobile crisis teams, assertive outreach for treatment in clients' own environments, individualized treatment, medication, rehabilitation, and supportive services.[145]

ii. Personal Care Services

Personal care services, authorized by section 1905(a)(24) of the Act and codified in regulation at 42 CFR 440.167, is an optional state plan benefit furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, or institution for mental disease. The services must be: "(1) Authorized by a physician in accordance with a plan of treatment or (at the option of the State) authorized for the individual in accordance with a service plan approved by the State; (2) Provided by a qualified provider who is not a legally responsible member of the individual's family; and (3) Furnished in a home and, at the State's option, in another location."

Personal care services can include a range of human assistance provided to persons with disabilities and chronic conditions enabling them to accomplish tasks they would normally be able to do for themselves if they did not have a disability. Depending on how broadly the state Medicaid agency defines this benefit, it can include: a) "assistance with activities of daily living (ADL) such as bathing, eating, dressing, mobility, and using the bathroom; and b) instrumental activities of daily living (IADL) such as financial management, taking medications, shopping for groceries."[146] Assistance may be in the form of hands-on assistance (actually performing the task for the individual) or cueing to prompt the individual to perform the task. For example, an individual may receive cueing assistance to take medication or for paying household bills on time, including rent and utility payments. These services may assist individuals with SUD who are at risk of homelessness or who have recently transitioned into independent community-based housing and need personal care supports to maintain housing.

iii. Rural Health Clinics/Federally Qualified Health Centers

Rural Health Clinics (RHC)/FQHC services are defined in sections 1905(*l*)(1) and (2) and section 1861(aa) of the Act. FQHC and RHC services are mandatory services for Medicaid state plans, intended to serve a medically underserved population and area. Services that a Medicaid state plan must cover, when offered by an RHC or FQHC, include primary and certain preventive services provided by physicians, nurse practitioners, physician assistants, certified nurse midwives, clinical psychologists, clinical social workers, and other ambulatory services offered by a RHC/FQHC which are otherwise included in the state plan. If applicable, RHC services also include visiting nurse services to persons who are homebound in an area where CMS has certified that there is a shortage of Home Health Agencies.

Some FQHCs specialize in serving special populations through Health Care for the Homeless programs. Health Care for the Homeless programs are community health centers that serve people experiencing homelessness, who are often disproportionately impacted by SUD, including OUD. These programs furnish intensive services to meet the specific needs of medically complex individuals. Health Care for the Homeless grantees are required to provide or arrange for SUD treatment services, and they typically provide more case management, outreach, and other support services than other health centers.[147] These programs are well-positioned to assist individuals experiencing homelessness to enroll or re-enroll in Medicaid, determine Medicaid eligibility, and help an individual to choose a Medicaid MCO, if applicable.

iv. Targeted Case Management Services

States can choose to furnish Targeted Case Management (TCM) services to assist Medicaid-eligible individuals in gaining access to needed services. States that elect to cover TCM services under the Medicaid state plan can target specific populations, such as Medicaid-eligible individuals with SUD, who are experiencing or at risk of experiencing homelessness. Additionally, states may furnish TCM services less than statewide.

TCM services, authorized under section 1905(a)(19) of the Act and codified in regulation at 42 CFR 440.169(b), include services that assist eligible individuals to gain access to needed medical, social, educational, and other services. Codified in regulation 42 CFR 440.169(d), the assistance that case managers provide in assisting eligible individuals obtain services includes comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services; development of a specific care plan;

referral to services; and monitoring and follow-up activities. TCM services can also include assisting individuals transitioning from a medical institution to a home in the community.

TCM services yield several flexible elements for addressing the needs of medically and socially complex individuals. As part of identifying the total needs of an eligible individual experiencing homelessness, TCM services can include linking the individual to needed housing resources, activities to help an individual find housing, and assisting with identifying resources to support the individual to maintain housing during a crisis. TCM services also assists individuals with gaining access to other needed medical, social, and educational services to help an individual achieve housing stability in the community.

A multi-disciplinary team approach may be employed to furnish TCM services. For example, case managers can coordinate the team's resources and expertise to inform a comprehensive, medical, educational, and social assessment as well as to create and implement a comprehensive plan of care. States may develop rates based on case or task complexity to reflect the need to draw on additional resources to develop and implement comprehensive assessments, care plans, and follow through activities.

b. Other Authorities Available to States

i. Section 1945 Health Homes

The health home state plan benefit authorized under section 1945 of the Act includes various services that help to ensure the coordination of all primary services, acute care services, behavioral health (including mental health and substance use) services, and long term services and supports for individuals with chronic conditions, and thus help to ensure treatment of the "whole person." Health homes are responsible for connecting beneficiaries to other social services and supports. CMS expects that health outcomes for Medicaid beneficiaries enrolled in health homes will improve, and that health homes will result in lower rates of ED use, reduction in hospital admissions and readmissions, reduction in health care costs and reliance on long-term care facilities, and improved experience of care for Medicaid individuals with chronic conditions.

Section 1945 of the Act specifies that the health home state plan optional benefit is for "eligible individuals with chronic conditions." States can specify which chronic conditions their health homes will target, but are not permitted to limit the benefit to specific age groups. Section

1945 defines health home services as comprehensive care management; care coordination and health promotion; comprehensive transitional care, including appropriate follow-up, from inpatient to other settings; individual and family support; referral to community and social supports, if relevant, and use of health information technology to link services, as feasible and appropriate. To qualify for health home services, Medicaid beneficiaries must: (1) have two or more chronic conditions; (2) have at least one chronic condition and be at risk of developing another; or (3) have at least one serious and persistent mental health condition. Chronic conditions specified in the statute are mental health conditions, SUD, asthma, diabetes, heart disease, and being overweight (i.e. Body Mass Index over 25). States may propose to target one or more conditions from the list, or, with approval from CMS, may target other conditions such as HIV/AIDS. States implementing the Medicaid section 1945 health home benefit receive enhanced federal matching funds for health home services for an initial period (90 percent federal match for health home services during the first eight fiscal quarters that the approved health home SPA is in effect). States can request an additional two quarters of enhanced federal match under SUD-focused health home SPAs approved on or after October 1, 2018. After the period of enhanced federal match ends, services are matched at the state's usual service rate.[148]

Under the Medicaid section 1945 health home option, states can provide comprehensive care management services that could include an assessment to identify the need for housing, which could then help the health home to refer an individual to community and social support services, including those that support independent community living or recovery. Health home services must include comprehensive transitional care, including appropriate follow-up, from inpatient to other settings. Medicaid health homes can support individuals as they transition between SUD treatment settings, as they reside in supportive housing or another model of affordable housing, or as they progress through different stages of their recovery process.

ii. Section 1915(b)(3)

Section 1915(b) waiver programs are used by states to implement a managed care or a FFS selective contracting delivery system for state plan benefits. States using this authority also have the ability to furnish additional services, beyond those covered in the state plan, through the use of a waiver under section 1915(b)(3), which allows a state to share the savings resulting from the use of more cost-effective care with Medicaid beneficiaries. These savings may be used in

the provision of housing-related services for enrollees to identify, transition to, and sustain their housing.

iii. Risk-Based Managed Care

States have options for how they choose to deliver Medicaid covered services to their beneficiaries, including Medicaid managed care. Regardless of authority, states that choose to use managed care delivery systems provide some or all Medicaid state plan benefits through an MCO, pre-paid inpatient health plan, or pre-paid ambulatory health plan.[149] Managed care plans enter into contracted arrangements with state Medicaid agencies to provide for all the services covered under the risk contract for a set amount, called a capitation payment (typically PMPM), regardless of whether the enrollee uses services. In addition to providing the state plan services and waiver services covered under the contract, managed care plans have the flexibility to pay for in-lieu-of, which could include housing-related services to the extent that the managed care plan chooses to do so voluntarily.[150]

States have a number of flexibilities under managed care programs to address the needs of complex populations such as individuals with SUD who are experiencing or are at risk of experiencing homelessness. For example, states can provide a managed care plan option and even passively enroll beneficiaries into a managed care plan with expertise and capacity for managing the complex needs of this population. States can also use managed care contracts to facilitate comprehensive care planning for this population, which may include directing the managed care plan to assess enrollee needs pertaining to housing-related services and provide linkages and referrals to community-based supports and services that could help them address these and other important social determinants of health. As noted above, section 1915(b)(3) waivers permit the furnishing of additional benefits based on the savings achieved through the more efficient provision of care in a managed care program; the regulation at § 438.3(e) permits managed care plans to voluntarily offer such services provided that the costs for them are not used in developing (or paid under) the capitation rates. This can be for the goal of improving quality of care and/or reducing costs and focusing on the whole person. For example, a managed care plan could elect to provide supportive housing for a participant with SUD who otherwise would cycle between hospital stays and homelessness. Costs associated with value-added services cannot be built into the capitation rates/premiums paid to the managed care plan.

c. Existing Opportunities under Sections 1915(c), 1915(i), and 1915(k) of the Act

Waiver authority found at section 1915(c) of the Act gives states the option to offer long-term care services and supports in home and community-based settings to individuals who would otherwise require institutional care. States have engaged in activities and developed programs that serve individuals in the most appropriate community setting rather than in an institution. These programs and activities include diversion programs to maintain individuals in the community and transition programs to actively move individuals from institutional settings to the community. Community transition services are non-recurring set-up expenses for individuals who are transitioning from an institution to a living arrangement in a private residence where the person is directly responsible for his/her own living expenses. Allowable expenses are those necessary to enable the person to establish a basic household that do not constitute room and board and may include security deposits required to obtain a lease; essential household furnishings including furniture, window coverings, food preparation items, and bed/bath linens; moving expenses; set-up fees or deposits for utilities; services necessary for the individual's health and safety such as pest eradication; necessary home accessibility adaptations; and activities to assess need, arrange for, and procure needed resources.

The 1915(c) authority has been used by states to offer varying service packages, including the provision of housing-related services, to individuals with mental health disorder and/or SUD and for those who are elderly or have physical disabilities, traumatic brain injuries, or developmental disabilities. Although many individuals with SUD who are experiencing or are at risk of experiencing homelessness have complex medical conditions, they may not meet the state's eligibility requirements for services in an institutional setting and therefore would not meet the institutional level of care eligibility requirement for a section 1915(c) waiver program. Under Medicaid HCBS waiver programs, housing-related supports and services are authorized based on an assessment of need and are identified in a person-centered service plan. The person-centered planning process reflects any needed services, including non-Medicaid community resources.

Section 1915(i) of the Act, enacted through the Deficit Reduction Act of 2005 (DRA), permits a state to furnish HCBS under the state plan without regard to whether Medicaid-eligible individuals require an institutional LOC. Under section 1915(i), eligible individuals are those who are eligible for medical assistance under the state plan, meet state-defined needs-based

criteria, and reside in the community. A 1915(i) SPA also offers states the option to target the benefit to a specific population based on age, disability, diagnosis, and/or Medicaid eligibility group. The lower threshold of needs-based criteria must be "less stringent" than institutional and HCBS waiver LOC. Needs-based criteria may include state-defined risk factors, including risk of or experiencing homelessness. Eligibility for the section 1915(i) state plan benefit may not be determined using only risk factors. States have the option to cover any services permissible under 1915(c) HCBS waivers, which include services necessary to live in the community.

Under section 1915(i) state plan HCBS, states may offer housing-related supports and services that are similar in nature to those offered under section 1915(c). These services may include assessment and care plan development of an individual's housing needs (including the identification of services not covered by Medicaid), tenancy sustaining services that provide skills to the individual on relationship building and community living, and linkages with other medical and non-medical services (similar to a case management function) once in their residence.

Individuals eligible for housing-related services under a section 1915(c) or 1915(i) Medicaid authority may need help with skills and functioning for daily living that are habilitative in nature. Defined at section 1915(c)(5) of the Act, "habilitation services means services designed to 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 skills can support an individual to successfully engage with the community-based housing system, particularly when interacting with neighbors, negotiating with landlords, and managing a household budget.

States can also propose "other" types of services that may assist in diverting individuals from institutional placement. Section 1915(c)(4)(B) references the services offered under section 1915(c), which includes other services requested by the state as the Secretary may approve. Individuals with SUD who are experiencing or are at risk of experiencing homelessness often transition between multiple living situations from the streets, shelters, across various SUD treatment settings, and supportive housing or another model of affordable housing as they progress though different stages of their recovery process. Access to tenancy sustaining services across these various settings helps to divert individuals from institutional placement.

The purpose of the section 1915(k) Community First Choice (CFC) benefit is to provide certain individuals, who meet an institutional level of care, the opportunity to receive necessary personal attendant services and supports in a home and community-based setting. There are required services that must be included in all CFC programs, as well as additional services that may be included at the state's option. States electing CFC are required to cover the following services, subject to the conditions described above: (1) services and supports to assist in accomplishing activities of daily living (ADLs), instrumental activities of daily living (IADLs) and health-related tasks, through hands-on assistance, supervision, and/or cueing; (2) acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs and IADLs and health-related tasks; (3) back-up systems or mechanisms to ensure continuity of services and supports; and (4) voluntary training on how to select, manage, and dismiss attendants. The optional services states may cover in their CFC benefit include: (1) expenditures for transition costs (such as first month's rent and utilities or bedding, basic kitchen supplies, etc.) necessary for an individual transitioning from an institutional setting to a home and community-based setting; and (2) expenditures relating to a need that increases an individual's independence or substitutes for human assistance, to the extent that Medicaid expenditures would otherwise be made for human assistance. As with personal care services authorized by section 1905(a)(24) of the Act, services authorized under the section 1915(k) state plan option may assist individuals with SUD who are at risk of homelessness or who have recently transitioned into independent community-based housing and need personal care supports to maintain housing.

d. Section 1115 Demonstrations

In general, the existing Medicaid authorities described above provide states the flexibilities necessary to offer coverage for housing-related services and supports for individuals with SUD who are experiencing or are at risk of experiencing homelessness. However, there may be instances when states want to consider seeking CMS approval for a demonstration project under section 1115 of the Act. Under section 1115 of the Act, the Secretary may approve any experimental, pilot, or demonstration project, that in the judgment of the Secretary, is likely to assist in promoting the objectives of certain programs under the Act, including Medicaid. Section 1115(a)(1) of the Act allows the Secretary to waive compliance with the Medicaid requirements of section 1902 of the Act, to the extent and for the period he finds necessary to carry out the

demonstration project. In addition, section 1115(a)(2) of the Act allows the Secretary to provide federal financial participation for demonstration costs that would not otherwise be considered as federally matchable expenditures under section 1903 of the Act, to the extent and for the period prescribed by the Secretary.[151]

Through section 1115 authority, CMS offers states the opportunity to test innovative approaches for improving treatment for individuals with SUD in ways that consider local challenges and response capabilities. For example, in 2017, State Medicaid Director Letter 17-003, *Strategies to Address the Opioid Epidemic*,[152] CMS offered states an opportunity to receive Federal Financial Participation (FFP) for the continuum of services to treat addiction to opioids or other substances, including services provided to patients in Institutions for Mental Diseases (IMDs). This demonstration opportunity also included an expectation that participating states would implement strategies to improve care coordination and transitions to community-based services and supports as individuals leave residential treatment or inpatient settings.

Section 1115 demonstrations generally include evaluation requirements and usually are approved for an initial 5-year period, with a possible 3-5-year renewal period(s) after the first 5 years.[153] Where possible, and subject to the public notice and transparency requirements, CMS may approve the extension of routine, successful, non-complex section 1115 demonstration and expenditure authorities in a state for a period up to 10 years, with the flexibility to approve more complex demonstration and expenditure authorities for shorter periods to allow CMS to assess the impact and continuation of these authorities.[154]

e. Money Follows the Person Demonstration

The Money Follows the Person demonstration, first authorized by Congress as part of the DRA in 2005 and then extended by the ACA in 2010, is designed to shift Medicaid's long-term care spending from institutional care to HCBS. The Money Follows the Person demonstration provides critical tools to address gaps in the availability of community services for Medicaid eligible individuals with disabilities and older adults. Since the demonstration began, state grantees have consistently noted the lack of affordable and accessible housing as a primary barrier to transitioning eligible individuals from medical institutions to the community.

Recognizing the difficulties faced by the Money Follows the Person population in finding housing, grantees have pursued several housing-related activities under the demonstration: **(**1) partnership building to increase the supply of housing options and resources, (2) testing services

to facilitate transitions to the community, and (3) testing services to provide assistance and support to individuals to secure and maintain community-based housing. Congress recently provided short-term funding to extend the demonstration through 2021 under the Medicaid Extenders Act of 2019 (H.R. 259) and under the Medicaid Services Investment and Accountability Act (H.R.1839).

f. Integrated Care Models and Payment Reform

Integrated care models can support a variety of innovative approaches to addressing the needs of individuals with SUD who are at risk of or experiencing homelessness, such as interdisciplinary care teams and comprehensive care coordination services, while providing flexibility for states to develop payment mechanisms that support intensive care interventions such as tiered rate methodologies and shared savings models. Integrated care models can include patient-centered medical homes, ACOs, or other models that emphasize person-centered, continuous, coordinated, and comprehensive care. Although there is no specific current statutory authority for ACOs within the Medicaid program, CMS released two letters to state Medicaid directors in 2012, providing guidance regarding Medicaid integrated care models, including ACOs and ACO-like models for payment and service delivery reform.[155] CMS also released guidance in a Center for Medicaid and CHIP Services Informational Bulletin in 2013, "*Targeting Medicaid Super-Utilizers to Decrease Costs and Improve Quality,"* clarifying how care delivery models such as integrated care models can help states and Medicaid providers to meet the complex needs of the highest utilizers of acute care in Medicaid populations.[156]

CMS allows states considerable flexibility in structuring payment mechanisms for ACO or ACO-like models that include FFS, managed care, and primary care case management.[157] CMS is working with states to move from volume-based FFS reimbursement to integrated care models with financial incentives to improve beneficiary health outcomes. States typically use a shared savings for total cost of care or global budget model to generate a financial incentive for providers to deliver value over volume. A shared savings model is similar to a fully capitated model whereby the state Medicaid agency enters into a partial risk-sharing arrangement with the care team organization. Under a global budget model, ACOs receive a capitated per-patient payment to provide services and accept full financial risk for the health of their patient population. The care coordination models typically include partnerships with community-based organizations, social service agencies, counties, and public health resources.[158]

States may choose to implement ACOs to better coordinate care for high-need, high-cost Medicaid beneficiaries, many of whom are individuals with mental health and substance use issues who are experiencing homelessness.[159] Access to high-quality care coordination and comprehensive recovery services and social supports is integral to improving health and managing costs for this population. ACOs form networks of providers that can include providers with expertise in delivering housing-related services and other recovery and social support services.

g. Administrative Procedures to Partner with Other Public Agencies

Some housing-related services and activities may be covered as Medicaid services. Other activities may promote the proper and efficient administration of the state plan and receive a Medicaid administrative match. Medicaid can be an integral part of a collaboration with other community-based programs, including state and local housing agencies that support individual's ability to live and receive needed care in their chosen community setting.

The effectiveness of these activities is based on collaboration across the many entities that serve individuals with SUD who are experiencing or are at risk of experiencing homelessness. For example, addressing the continuum of housing needs for this population requires collaborations between state Medicaid agencies, behavioral health agencies, state housing financing agencies, public housing agencies, and other affordable housing providers to increase opportunities for community living. State Medicaid agencies employing individuals to perform partnership building and housing collaboration activities may claim the 50 percent administrative claiming rate for these activities if the costs can be recognizable as allowable Medicaid administrative costs, only to the extent that the state has documented that the costs directly benefit the Medicaid program and are claimed consistent with federal cost allocation principles. These activities are focused on coordination between various agencies to increase housing availability in contrast to activities focused on helping beneficiaries find housing.

Studies on health and housing programs indicate that integrated information systems and data sharing capabilities at the state level are critical to supporting the evolving role of states in assuring appropriate, accessible, and cost-effective care for individuals with SUD who are experiencing or are at risk of experiencing homelessness.[160] The U.S. Department of Health and Human Services *5-Point Strategy to Combat the Opioid Crisis*[161] emphasizes the importance of improving access to prevention, treatment, and recovery support services, including the full

range of MAT, and strengthening our understanding of the crisis through better public health data and reporting. Medicaid offers a variety of pathways to support the design and development of statewide data and analytic infrastructure to address the opioid crisis and to better meet the housing and health care needs of individuals with SUD who are experiencing or at risk of experiencing homelessness.

CMS issued an SMDL, "*Leveraging Medicaid Technology to Address the Opioid Crisis*" on June 11, 2018, to describe the ways technology might support states' efforts to address the needs of individuals with OUD. The SMDL emphasizes leveraging existing authority contained in the final rule titled "Mechanized Claims Processing and Informational Retrieval Systems (90/10)" and in the Health Information and Technology for Economic and Clinical Health (HITECH) Act.[162] Under the HITECH Act, states can receive an enhanced federal matching payment to support the design and development of real-time admission/discharge/transfer data feeds, data analytic tools, and decision support systems. States can connect various data sources from such entities as public health agencies, human services programs, housing programs, emergency medical services providers, Medicare, or justice-related systems in support of the interoperability standards under 42 CFR 433.112(b)(16).[163] The Transformed Medicaid Statistical Information System[164] provides states with additional capabilities to monitor beneficiary and provider utilization and cost trends for housing-related services covered under their Medicaid programs. The enhanced data available under the Transformed Medicaid Statistical Information System will support improved program and financial management and more robust evaluation of demonstration programs. Leveraging these data integration and data sharing Medicaid technology resources can assist state health systems to identify individuals with SUD who are experiencing or are risk of experiencing homelessness and link them to appropriate medical services, housing-related services, and recovery supports.

VII. Innovative Strategies and Partnerships Developed and Implemented by State Medicaid Programs or Other Entities to Identify and Enroll Eligible Individuals with SUD Who Are Experiencing or at Risk of Experiencing Homelessness in State Medicaid Programs (SUPPORT Act, Section 1017(b)(5))

Individuals with SUD who are experiencing or are at risk of experiencing homelessness face unique barriers to enrolling in Medicaid programs and may need special outreach, education, and assistance. A critical pre-tenancy need among those experiencing homelessness who may not be engaged in or otherwise seek out services is for outreach and engagement that meets individuals where they are, including on the streets and in shelters or places not meant for human habitation, in order to connect them with housing and other needed supports.[165] Many individuals experiencing homelessness with SUD or co-occurring substance use and mental health disorders are disengaged from and distrustful of public systems, often requiring months of outreach and relationship building. Overcoming this challenge often requires gradual and targeted engagement to establish trust and rapport, together with one-on-one assistance to navigate through the enrollment process.[166] Individuals experiencing homelessness may also face multiple challenges to completing the Medicaid enrollment process, including language and literacy barriers, transportation challenges, unstable contact information, and lack of documentation.[167] These barriers may lead to gaps in Medicaid coverage and may disrupt access to and continuity of care. This section of the report identifies several Medicaid regulations states must comply with when enrolling individuals who are experiencing homelessness and highlights innovative state activity around identifying, engaging, and enrolling individuals who are experiencing homelessness, a subset of which likely includes individuals with SUD.

a. Medicaid Regulations

Several CMS regulations and policies regarding enrollment procedures in State Medicaid programs provide flexibility to states to address some of the more unique needs of individuals who are experiencing homelessness. These include residency requirements, application assistance, and documentation requisites for verification purposes.

In accordance with 1902(b)(2) of the Act and 42 CFR 435.403(h) and (i), Medicaid does not require an individual to have a fixed or home address in the state. Individuals who are experiencing homelessness may use the mailing address of a homeless shelter, drop-in center,

clinic, county welfare or public health department, mental health service provider, or SUD treatment program, among others.[168]

42 CFR 435.908 requires states to aid individuals who seek help with the application process and/or renewal process. 42 CFR 435.923 discusses authorized representatives, who are individuals or organizations designated by applicants/beneficiaries to act on behalf of the applicant/beneficiary for the purposes of the application, renewal, and other ongoing communications with the state Medicaid agency. Providers of services to individuals who are experiencing homelessness can provide information and various forms of assistance on Medicaid enrollment, such as conducting general outreach and education, assisting with "navigation" around the Medicaid application process, or being designated as an authorized representative on a Medicaid application.[169] Safety-net hospitals and community health centers can conduct "in-reach" to individuals they already serve to enroll people into Medicaid.[170] FQHCs, including Health Care for the Homeless programs, can conduct outreach to uninsured individuals in the communities they serve and are positioned to assist individuals experiencing homelessness to enroll or re-enroll in Medicaid, determine Medicaid eligibility, and help an individual to choose an MCO if applicable.

42 CFR 435.952(c) specifies that individuals must not be required to provide additional information or documentation unless information needed in accordance with 42 CFR §§ 435.948, 435.949, or 435.946 cannot be obtained electronically or the information electronically is not reasonably compatible, as provided in the verification plan described in 42 CFR 435.945(j), with information provided on or behalf of the individual. 42 CFR 435.952(c)(3) provides a special circumstances exception, which generally requires that states permit, on a case-by-case basis, self-attestation when documentation does not exist or is not reasonably available at the time of application or renewal, such as in the case of individuals who are homeless.

Federal matching funds under Medicaid are available for costs incurred by the state for administrative activities that directly support efforts to identify and enroll potential eligible individuals into Medicaid and that directly support the provision of medical services covered under the state Medicaid plan, when those activities are performed either directly by the state Medicaid agency or through contract or interagency agreement by another entity. Medicaid administrative activities include certain activities that are "proper and efficient" for the state's administration of its Medicaid program. These activities may include outreach; referral,

coordination, and monitoring of Medicaid services; facilitating Medicaid applications; and coordinating transportation.[171] For example, the Maricopa County program employs peer navigators with lived experience of SUD and homelessness to conduct outreach and engagement activities. The Los Angeles County Whole Person Care pilot uses community health workers, many of whom have lived experience of SUD and are in recovery, to engage individuals and to assist individuals to enroll in Medicaid and thus access covered services.

b. Identifying Individuals with SUD Who Are Experiencing Homelessness

There is no standardized or required methodology for identifying individuals who are experiencing homelessness under the Medicaid program. The International Classification of Diseases, Tenth Revision (ICD-10) covers factors influencing health status and contact with health services, including a code (Z59.0) available for tracking and reporting homelessness. CMS and the Centers for Disease Control's National Center for Health Statistics have developed official guidelines for coding and reporting of ICD-10-CM data. The guidelines specify that Z-codes can be used in any health care setting.[172] According to an NHCHC report, "documenting homelessness in a patient's medical record can be a vital way for hospitals, health centers and insurance plans to identify individuals who need targeted health care and housing interventions, and to inform emerging payment methodologies."[173] However, recent research indicates that the use of Z-codes is inconsistent and providers do not always screen or document housing status.[174]

Several states have initiated effective strategies to identify individuals who are experiencing homelessness by partnering with homeless service providers, MCOs, hospitals, and other public systems to compare multiple data sources. Having SUD or a SUD treatment encounter was highly prevalent among this population in the following examples. In Connecticut, the state matched Medicaid claims data to HMIS data to identify high-cost, high-need Medicaid beneficiaries who were then prioritized for supportive housing programs.[175] In Texas, under the section 1115 Healthcare Transformation and Quality Improvement Program demonstration, health care utilization data were linked with HMIS data to find individuals experiencing chronic homelessness in Houston for participation in the Integrated Care for the Chronically Homeless initiative.[176] Under California's section 1115 Medi-Cal 2020 demonstration, the Whole Person Care Los Angeles Pilot, county safety net hospitals have created a homelessness flag in their data system to identify individuals who may qualify for the program.[177] The Camden Coalition Medicaid ACO and two local hospitals developed an

arrangement whereby the Coalition receives an email of a daily list or "snapshot" of patients currently in the hospital with two or more inpatient admissions and/or six or more ED visits in the last 6 months. The Coalition team reviews the daily admission cases to identify potential participants to their integrated care coordination program.[178]

An independent evaluation of the City of Philadelphia's Encampment Resolution Pilot, an initiative to shut down two homeless encampments located in the Kensington section of Philadelphia, highlighted an innovative approach to identifying and tracking individuals experiencing chronic homelessness called the By-Name List. The By-Name List is a comprehensive list of all persons eligible to receive housing and substance use services in the Encampment Resolution Pilot program, identified through an Outreach Encampment Survey. Identifiers were available for those on the By-Name List, enabling matching the list to service records in the City of Philadelphia's CARES Integrated Data System. Among those most targeted for services through the pilot, 55 percent were actively enrolled in Medicaid, and 90 percent were matched with some type of record in the City's homeless, behavioral health, and/or prison systems. By-Name Lists have emerged fairly recently as a key tool for identifying and tracking individuals who are chronically homeless and otherwise challenging to serve.[179]

c. Outreach and Engagement

Outreach to and engaging individuals experiencing homelessness with SUD typically requires skilled behavioral health staff working in partnership with peer professionals in long-term recovery and is a gradual process that can take significant time, ranging from a few visits to weekly visits over the course of many months.[180] Effective outreach and engagement that also incorporates evidence-based practices, such as motivational interviewing[181] and trauma-informed care, facilitates access to needed benefits, such as Supplemental Security Income/Social Security Disability Income and Medicaid, and ensures coordination with housing and service providers. Partnerships between homeless service providers and law enforcement, jails, prisons, hospitals, and others who frequently come in contact with individuals in this population are often part of the process. Connecting with individuals at risk of homelessness as they exit correctional, behavioral health, and other institutional settings is also often necessary to prevent individuals from becoming homeless.[182]

A Kaiser Family Foundation study titled "*Early Impacts of the Medicaid Expansion for the Homeless Population"* noted that frontline outreach and enrollment workers conduct

outreach in a wide range of community locations, including emergency shelters, encampments, under bridges, parole and probation offices, day programs/drop-in centers, hospital emergency rooms, churches, and food pantries or soup kitchens.[183] The state programs interviewed for this report hire peer support specialists or community health workers[184] to provide outreach and engagement. The Maricopa County program employs peer navigators with lived experience of SUD and homelessness. The Los Angeles County Whole Person Care pilot hires community health workers who report directly to Licensed Clinical Social Workers.[185] Washington adopted a "no-wrong-door" approach to expedite enrollment for individuals experiencing homelessness in addition to providing tailored training to homeless outreach staff on how to navigate through the no-wrong-door system.

d. Enrolling Justice-Involved Individuals Who Are at Risk of Homelessness

In accordance with section 1905(a)(30)(A) of the Act, the Medicaid statute generally excludes payment for services for an eligible individual who is an inmate at a public institution (except as a patient in a medical institution). However, Medicaid coverage can be crucial to ensuring a successful transition following incarceration. Many individuals in the justice-involved population have a high prevalence of long-untreated, chronic health care conditions as well as a high incidence of substance use and mental health disorders. An estimated 65 percent of incarcerated individuals have an SUD.[186] Over 10 percent of persons released from prisons and jails face homelessness upon reentry—a percentage that could be as high as 50 percent in large, urban areas.[187] With expansion of Medicaid to the new adult group under the ACA, more incarcerated individuals became eligible for Medicaid. CMS released new guidance in April 2016 on how states and localities may facilitate access to Medicaid coverage for individuals before, during, and after a correctional institution stay.[188] Additionally, section 5032 of the SUPPORT Act, Medicaid Reentry Act, requires the secretary to convene a stakeholder group to identify best practices around connecting individuals to coverage upon reentering the community following incarceration, issue a report to Congress, and requires the HHS Secretary to issue a state Medicaid director letter regarding section 1115 demonstrations to improve transitions for individuals moving from incarceration to the community.

A 2016 Pew Charitable Trust report identified several strategies that states were employing to enroll justice-involved individuals in Medicaid. For example, the Ohio Department of Rehabilitation and Correction partners with the state's Medicaid agency to enroll inmates and

facilitate their selection of a Medicaid managed care plan 90 days before their release, with the goal of reducing recidivism by helping inmates' access appropriate medical, mental health, and SUD services prior to release. Ohio uses peers to help incarcerated individuals learn about plan enrollment and how to apply for Medicaid.[189] Some states are providing care coordination prior to release for justice-involved individuals; however, Medicaid can only cover the cost of services provided to eligible individuals after returning to the community.[190]

VIII. Conclusion

Section 1017 of the SUPPORT Act requires that "the Secretary issue a report on innovative state initiatives and strategies for providing housing-related services and supports under a state Medicaid program to individuals with SUD who are experiencing or at risk of experiencing homelessness." States have implemented various initiatives and strategies under section 1905(a), section 1915, section 1945, and section 1115 authorities to provide housing-related services and supports to these individuals.

As this report detailed, homelessness is strongly correlated with SUD. Substance use can be both a cause and consequence of homelessness, and a significant barrier to exiting homelessness. States often identified experiencing or risk of experiencing homelessness as a risk factor for determining eligibility for Medicaid-funded HCBS. Individuals with SUD experiencing or at risk of experiencing homelessness were highly represented within this target group.

States are testing a variety of approaches and strategies to address housing stability needs and to improve treatment outcomes for individuals with SUD who are experiencing or at risk of experiencing homelessness. State initiatives focus on providing housing-related services that facilitate access to community resources; sharing data across systems to identify and target those most in need for those resources; and implementing housing-related initiatives involving partnership building and collaboration across state and local health and housing systems and providers. States designed programs to create flexible access to resources and services and to build the capacity of communities to deliver coordinated care and improve housing choice for individuals with SUD who are experiencing or at risk of experiencing homelessness.

Many of the state initiatives covering housing-related services that have been highlighted in this report are too early in the program implementation stage to share independent evaluation

information on best practices and whether the programs are achieving expected outcomes. Evaluations are forthcoming for the section 1115 demonstrations. For instance, California's Whole Person Care pilot program final evaluation will be completed by June 30, 2021. "The Whole Person Care Pilot Evaluation" will assess: 1) if the pilots successfully implemented their planned strategies and improved care delivery, 2) whether these strategies resulted in better care and better health, and 3) whether better care and health resulted in lower costs through reductions in avoidable utilization."[191] States are also showing increasing interest in covering housing-related services and supports for the under section 1915(i) and the Medicaid section 1945 health home option. CMS remains available to provide technical assistance to states based on their population demographics and policy goals.

APPENDIX A: Case Studies

a. Maricopa County, Arizona—Mercy Care Comprehensive Community Health Program

Goals and objectives for housing supports, specific to Medicaid-eligible individuals with a substance use disorder. Mercy Care is an integrated physical and behavioral health Medicaid managed care plan that primarily serves members in Maricopa County, Arizona. Mercy Care also is contracted by the state Medicaid agency as the Regional Behavioral Health Authority for Maricopa County to provide integrated behavioral health and physical health services to Medicaid-eligible adults with serious mental illness, as well as mental health and substance use disorder (SUD) services to Medicaid-eligible individuals without a serious mental illness diagnosis.

The Comprehensive Community Health Program is a program developed by Mercy Maricopa to serve adult plan members who are high-cost, high-need beneficiaries who are experiencing or are at risk of homelessness with opioid use disorder, another SUD, and/or mental health disorder who do not meet the serious mental illness threshold. This population frequently accesses care in crisis and hospital settings. The program began in 2015.

Target population. All high-cost, high-need Medicaid beneficiaries with a mental health disorder, a SUD, or both who are experiencing or at risk of homelessness, including single individuals and families, qualify for the Comprehensive Community Health Program. Currently, 275 households are enrolled, most of which have a history of SUD. Participants are referred by the hospital system, the Mercy Care internal case management system, other community providers, and the criminal justice system. The managed care organization (MCO) is reviewing its data and data from the Homeless Management Information System (HMIS) and local hospital data to help identify the individuals in the target population.

Geographic focus. This program is offered throughout Maricopa County, which is the central county of the Phoenix-Mesa-Glendale, Arizona Metropolitan Statistical Area.

Model overview. The Comprehensive Community Health Program offers primarily scattered site permanent supportive housing using a Housing First approach. The City's Public Housing Authority has dedicated Department of Housing and Urban Development (HUD)-funded section 8 Housing Choice Vouchers for rental assistance. Medicaid-funded housing-related services are offered using a multidisciplinary team that provides intensive community-

based services that include many individual housing transition and tenancy sustaining services. Move-in resources such as deposits, move-in kits, and furniture are provided through a partnership with Valley of the Sun United Way.

Under this model, peer navigators with experience with SUD and homelessness provide outreach and engage individuals in the program. Participants are provided with care coordination to access other services, including physical and behavioral health care, peer supports, and supported employment, as well as medication-assisted treatment (MAT) when clinically indicated and desired. The program also works to prevent or divert homelessness among those considered potentially high risk or high need by supporting them in their current location.

As of October 1, 2018, new rates went into effect on a fee-for-service basis. Mercy Care worked to develop rates that took outreach and engagement into consideration. The reimbursement system has a value-based payment component for meeting certain metrics, including housing retention. Model outcomes to date and data sharing are listed below:

- **Number of individuals served.** Since the program's inception in 2015, more than 500 members have been served.
- **Service utilization and expenditure information.** For the period of 10/1/2016 through 9/30/17, the CCHP program demonstrated a 25 percent decrease in crisis utilization by program participants.
- **Description of any data sharing across systems.** Mercy Care is the clearinghouse for establishing eligibility for the Comprehensive Community Health Program based on claims and utilization data. They are working to develop data sharing partnerships with the state-supported health information exchange and HMIS. They already partner with the state Medicaid agency.
- **Evaluation methods and information on outcomes.** Arizona is evaluating its section 1115 demonstration, which includes authority for Mercy Care to provide the Comprehensive Community Health Program housing support services. The Arizona Medicaid section 1115 demonstration annual report for FFY 2018 includes results from Mercy Care in Maricopa County for members with serious mental illness including, but not limited to, Plan All-Cause Readmissions, Ambulatory Care Emergency Department Visits, Inpatient Utilization Total Days per 1,000 member months and both 7- and 30-Day Follow-Up After Hospitalization for Mental Illness.[192] These data, however, relate to

a far larger population than the group using the Mercy Care Comprehensive Community Health Program. For available data from the Comprehensive Community Health Program, see service utilization and expenditure information above.

Partnerships employed to manage and coordinate projects.

- **Medicaid managed care organizations.** Mercy Care is the Medicaid MCO for this geographic region.
- **Health systems and hospitals.** The hospital system is the largest referral source for the Comprehensive Community Health Program. Housing support providers typically connect with individuals prior to hospital discharge. Referrals are also identified by the high-cost high-needs Mercy Care Liaison within the Care Management department.
- **State and local housing agencies.** The City of Phoenix Housing Department, the local housing authority, has designated rental assistance to support housing units that program participants occupy. Comprehensive Community Health Program providers of housing-related supports are a part of the local HUD-funded Continuum of Care program and ensure that eligible individuals go through the Coordinated Entry System as well in the event that other housing resources are necessary. When designing the program, Mercy Care conferred with the local housing community to help ascertain which providers to work with. Additionally, the program has focused on relationship building with landlords to address stigma associated with renting to members of the target population.
- **Federally Qualified Health Centers (FQHC) Health Care for the Homeless programs.** Mercy Care does not presently partner with a FQHC for the Comprehensive Community Health Program. The level of behavioral health acuity was so high initially that more intensive behavioral health care than is typically offered by FQHCs was needed. Moving forward, it will be connecting with FQHCs.
- **Other partnerships.** In addition to partnerships mentioned above, Mercy Care partners with providers (housing and behavioral health, including MAT providers), Maricopa Correctional Health (for members with high recidivism rates), and Valley of the Sun United Way (the latter for funding of move-in expenses).

b. California Whole Person Care Pilots/Los Angeles and Placer Counties

Goals and objectives for housing supports, specific to the population with a substance use disorder. Since 2017, California has been implementing Whole Person Care pilots authorized under section 1115 authority. Whole Person Care pilots are county-based initiatives that target Medicaid beneficiaries who are high utilizers of services. Counties provide matching funds and have flexibility to design their pilots with regard to eligibility and services. The goals of Whole Person Care pilots are to provide comprehensive integrated health, behavioral health, and social services for targeted beneficiaries to improve health outcomes using patient-centered and innovative practices. Increasing access to housing and related supportive services is one optional goal, and pilots can choose to fund individual housing transition and tenancy sustaining services to address the needs of their targeted populations. Under the Whole Person Care pilots, federal Medicaid funds may not be used to cover the cost of room and board, monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversional/recreational purposes. State or local government and community entity contributions are separate from federal matching funds, and may be allocated to fund support for long-term housing, including rental housing subsidies.[193]

The Medicaid reimbursement approach varies by pilot and by the service or support provided. The demonstration includes incentives for achievement of metrics; there also is some pay for reporting. The state is trying to move the whole system away from volume-based payment.

Target population. Just under half of the Whole Person Care pilots focus on beneficiaries with a substance use disorder (SUD), a mental health disorder, or both, and many target individuals who are experiencing or at risk of homelessness. Some pilots specifically target individuals with SUD, although this group is a subset of the target population for others. As of the third quarter of 2018, Whole Person Care pilots were serving approximately 85,000 individuals; the state projects it will serve up to 150,000 individuals.

Geographic focus. There are 25 Whole Person Care pilots across the state including one being implemented by a city (Sacramento) and one two-county pilot. Pilots in two locations, Los Angeles and Placer Counties, are discussed below and offer examples of pilots serving individuals with an SUD who are experiencing or are at risk of experiencing homelessness in urban and more rural communities.

Model overview. Los Angeles County's Whole Person Care pilot includes several different programs targeted to serve specific high-risk populations (e.g., homeless, high-risk maternity). Sixty percent of the County's Whole Person Care funding is targeted for the homeless population. Under the County's Housing for Health initiative, individuals who are experiencing or at risk of homelessness, many of whom have behavioral health conditions (87 percent meet the U.S. Department of Housing and Urban Development (HUD) definition of chronic homelessness, and most have SUD), are offered scattered site or project-based permanent supportive housing using federal or local rental subsidies or rapid rehousing using short-term locally funded subsidies. Through Whole Person Care-funded Homeless Care Support Services, individuals are provided intensive case management using a harm reduction approach. Wraparound services provided include a rich array of Medicaid-funded individual housing transition and tenancy sustaining services. Homeless Care Support Services case managers, who work for contracted local homeless service provider organizations, also assess and link individuals to needed primary care, mental health, and/or SUD treatment and provide ongoing care coordination. Referrals may come from a variety of sources including but not limited to the County's homeless Coordinated Entry System, hospitals, and street outreach funded by local Measure H[194] sales tax and other funds.

Los Angeles County also operates a Whole Person Care pilot program focused on helping individuals with SUD who are high utilizers of hospital emergency departments and inpatient settings, residential treatment, or sobering stations and/or have a high level of contact with law enforcement. The program assists individuals to (1) navigate the system; (2) find client-centered SUD treatment options; (3) increase harm reduction efforts; and (4) connect to primary care and other needed services and resources including housing. Community health workers, many of whom have a personal history of SUD in recovery, work to engage individuals in locations, such as hospitals, the community, or the streets, or through a 24/7 call line, and navigate the system over a 2-month period. Community health workers may assist individuals in accessing the Housing for Health or other housing options, provide personal referrals and set up appointments for those programs or others that will provide longer-term case management services. Individuals with SUD who may not be eligible for these programs may be provided short-term housing stabilization assistance along with pre-tenancy supports to assist with the acquisition of permanent housing.

Placer County's Whole Person Care pilot is primarily focused on serving individuals experiencing homelessness who have both primary SUD and co-occurring mental illness and SUD. Referrals come through the HUD-funded local Continuum of Care's (CoC's) Coordinated Entry System whereby individuals are prioritized for available housing options that may include transitional housing or permanent supportive housing offered in both scattered site and congregate locations. The program uses a Housing First and harm reduction approach, although challenges exist regarding housing providers' willingness to house those who are actively using alcohol and/or drugs. The County's Whole Person Care pilot provides many Medicaid-funded individual housing transition and tenancy sustaining services, and also coordinates referrals to outpatient treatment, 12-step recovery groups, and medication-assisted treatment. Placer County notes as particular challenges the lack of transportation resources in more remote areas of the County for individuals to access services, and limited housing options. Model outcomes to date and data sharing are summarized below:

- **Number of individuals served.** Los Angeles County served 11,393 individuals in permanent supportive housing and higher levels of care between January 2017 and December of 2018 and 2,256 in rapid rehousing between January 2017 and December 2018. The Los Angeles Whole Person Care pilot SUD program has the capacity to serve 480 individuals at any given time or 2,880 over the course of a 12-month period. Placer County Whole Person Care pilot currently has 277 people enrolled, 184 of whom are identified as having SUD, and projects serving up to 450 individuals over the life of the project. Although not yet available, the state intends to have data on the number of participants with SUD served by Whole Person Care pilot programs.
- **Service utilization and expenditure information**. The state will have an evaluation of encounter and claims data for all enrolled. It expects enrollment and claims through mid-2018 to be available by the end of 2019. After 2020, the state will have comprehensive data. Preliminary information is available for the pilots interviewed for their universal and variant metrics. See below regarding evaluation methods and information on outcomes.
- **Description of any data sharing across systems.** The state is focused primarily on examining Medicaid data. However, many local pilots have developed data-sharing platforms or methods to share data across system partners. For example, Placer County

shares data across behavioral health provider electronic health records, managed care organizations (MCOs), and the Homeless Management Information System.

- **Evaluation methods and information on outcomes**. Consistent with the terms of California's section 1115 demonstration entitled "California Medi-Cal 2020 Demonstration," a state-level evaluation will be conducted, and some individual pilots will conduct their own evaluations. Measures and outcomes to be examined as part of the state-level evaluation of the Whole Person Care program include but are not limited to (1) participant characteristics that include physical and behavioral health diagnoses, jail involvement, and housing needs; (2) duration and intensity of services; (3) progress toward pilot goals in relation to social services; (4) increased access to housing and supportive services; (5) improved housing stability; (6) other health measures; and (7) effects on costs of care. Counties also will examine their own metrics based on individual pilot objectives.

  Placer County's Mid-Year Report dated August 31, 2018 indicates that for Pilot Year 2:

  - Universal Metric – 70 percent of Whole Person Care members with a primary diagnosis of mental illness who are seen in the emergency department will have a Comprehensive Complex Case Coordination (CCCC) visit within 7 days: Metric Met with 92 percent.
  - Universal Metric – 80 percent of Whole Person Care members with a Serious Mental Illness will receive a CCCC service following discharge from a psychiatric hospital within 30 days: Metric Met with 86 percent.
  - Universal Metric – 70 percent of Whole Person Care members will have a completed Assessment and Tailored Plan of Care within 30 days of enrollment to Whole Person Care: Metric Met with 100 percent receiving timely Whole Person Care Assessment and 98 percent receiving timely Tailored Plan of Care.
  - Variant Metric – Percent of Whole Person Care members discharged from Index Hospital Stays who are not re-hospitalized within the next 30 days. Goal: 55 percent (Year 2): Metric Met with 65 percent.[195]

Los Angeles County's publicly available Annual Report dated April 27, 2018 does not include the universal and variant metric results for Pilot Year 2.[196]

Partnerships employed to manage and coordinate projects.

- **Medicaid managed care organizations.** Each jurisdiction works with at least one associated MCO, and some partner with several.
- **Health systems and hospitals.** Health and hospital system involvement varies by local pilot. Hospitals typically serve as a referral source for pilot services and, in some cases, a location where individuals can begin to be engaged. Placer County is an example of a Whole Person Care pilot that developed a flexible housing pool in partnership with an area hospital that can be used to fund housing costs not eligible for federal financial participation.
- **State and local housing agencies.** Whole Person Care pilots, focused on serving individuals at risk of or experiencing homelessness, collaborate with local housing authorities and HUD CoCs to access housing subsidies for participants. Many eligible participants are assessed through the local CoC's CES using the Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT©) or locally adapted vulnerability assessment tools in order to be prioritized for CoC housing resources. Many also work to develop relationships with landlords to encourage increased housing opportunities for their target populations and address stigma related to SUD.
- **Federally Qualified Health Centers (FQHCs) Health Care for the Homeless programs.** Collaboration varies by pilot. FQHCs and other community health clinic settings are an important resource for many Whole Person Care pilots to coordinate with to access primary care for their target populations. Both Los Angeles and Placer Counties work with multiple FQHCs.
- **Other partnerships.** The partnerships are specific to each pilot. For example, some have community partners for funding housing-related activities that are not eligible for FFP. Placer County developed a partnership with Sutter Health and the county Mental Health Services Act (MHSA) to fund affordable housing units for program participants.[197] The Los Angeles Department of Public Health is in the process of finalizing memoranda of agreement with the Department of Mental Health and the Public Defender's Office to co-locate navigators under the Client Engagement Navigation Services, which offer engagement, screening, and connections to SUD treatment services. Placer County works with the probation department and others.

c. Maryland Assistance in Community Integration Services

The Maryland Assistance in Community Integration Services pilot was specifically mentioned in section 1017(b)(4) of the SUPPORT Act as one example of a state providing housing-related services and supports through a section 1115 demonstration.

Goals and objectives for housing supports, specific to the population with a substance use disorder. The pilot was authorized under Maryland's Health Choice section 1115 demonstration, effective July 2017 with staggered start dates. Local government entities were invited to competitively apply for federal matching funds (with local jurisdictions providing the entire 50 percent non-federal match) to provide a set of home and community-based services inclusive of housing-related services to high-risk, high-utilizing Medicaid enrollees to reduce unnecessary and inappropriate healthcare service utilization and improve health and housing stability.

Target population. Assistance in Community Integration Services pilots are not specifically targeted to serve individuals with a substance use disorder (SUD), although, individuals with a SUD are enrolled. The program originally was capped at serving 300 Medicaid enrollees statewide who meet needs-based criteria annually (since increased to 600 enrollees through an approved section 1115 demonstration amendment). Specifically, the state's needs based criteria are: (1) Health criteria (at least one): (a) Repeated incidents of emergency department use (defined as more than 4 visits per year) or hospital admissions; **or** (b) Two or more chronic conditions as defined in section 1945(h)(2) of the Social Security Act. (2) Housing criteria (at least one): (a) Individuals who will experience homelessness upon release from the settings defined in 24 CFR 578.3; **or** (b) Those at imminent risk of institutional placement.[198] The state was unable to provide current enrollment data on individuals with an SUD experiencing or at risk of experiencing homelessness due to a claims lag.

Geographic focus. The Assistance in Community Integration Services pilot currently is available in four counties: Cecil, Montgomery, and Prince George's Counties and Baltimore City. Cecil County is a rural county and has more limited housing resources in comparison to the other three counties.

Model overview. Each county has designed its pilot on the basis of the needs of the populations being served. Coordination is required with relevant managed care organizations (MCOs) and Medicaid providers to access and provide needed services, and provider types and

service delivery models differ on the basis of local resources. For example, Baltimore City partners with Baltimore Health Care for the Homeless program, a Federally Qualified Health Center (FQHC), whereas Cecil County has a single case manager embedded within the county's health department. At least one jurisdiction uses peer support specialists. The housing-related services offered through Assistance in Community Integration Services include the following: (1) Tenancy-Based Case Management Services/Tenancy Support Services: Assist the target population in obtaining the services of state and local housing programs to locate and support the individual's medical needs in the home. These services may include:

- Conducting a community integration assessment identifying the participant's preferences related to housing (type, location, living alone or with someone else, identifying a roommate, accommodations needed, or other important preferences) and needs for support to maintain community integration (including what type of setting works best for the individual), assistance in budgeting for housing/living expenses, assistance in connecting the individual with social services to assist with filling out applications and submitting appropriate documentation in order to obtain sources of income necessary for community living and establishing credit, and in understanding and meeting obligations of tenancy.
- Assisting individuals to connect with social services to help with finding and applying for housing necessary to support the individual in meeting their medical care needs. This may include arranging for or providing transportation for services provided in the plan of care. Developing an individualized community integration plan based upon the assessment as part of the overall person centered plan. Identifying and establishing short and long-term measurable goal(s) and establishing how goals will be achieved and how concerns will be addressed.
- Participating in person-centered planning meetings at redetermination and/or revision plan meetings as needed.
- Providing supports and interventions per the person-centered plan (individualized community integration portion).
- Providing supports to assist the individual in communicating with the landlord and/or property manager regarding the participant's disability (if authorized and appropriate),

detailing accommodations needed, and addressing components of emergency procedures involving the landlord and/or property manager.

- Coordinating with the individual to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.
- Connecting the individual to training and resources that will assist the individual in being a good tenant and in lease compliance, including ongoing support with activities related to household management.

(2) Housing Case Management Services - may include:

- Service planning support and participating in person-centered plan meetings at redetermination and/or revision plan meetings as needed;
- Coordinating and linking the recipient to services including primary care; substance use treatment providers; mental health providers; medical, vision, nutritional and dental providers; vocational, education, employment and volunteer supports; hospitals and emergency rooms; probation and parole; crisis services; end of life planning; and other support groups and natural supports;
- Entitlement assistance including assisting individuals in obtaining documentation, navigating and monitoring application processes and coordinating with the entitlement agencies; and
- Assistance in accessing supports to preserve the most independent living, including skills coaching, financing counseling, anger management, individual and family counseling, support groups and natural supports.[199]

Providers are required to use a harm reduction approach in delivering program services. Many jurisdictions reportedly use the Coordinated Entry System (CES) list to identify individuals in need of services and some are opening up to referrals from community partners (e.g., parole and probation) after working through that list. There is no alcohol- and drug-free housing specifically available to Assistance in Community Integration Services pilot participants.

Housing resources differ by pilot location, and each has its own protocol for housing referral. Some use a Housing First approach, and most use the HUD CoC CES to document eligibility and triage the highest priority individuals to access the housing available through the

CoCs. Housing options range from site based to scattered site and include both permanent and transitional housing, with housing options more limited in the one rural pilot site (Cecil County).

Medicaid payment is per member per month, based on a negotiated rate that varies by jurisdiction. If three or more of the listed services are provided to a member within a calendar month, the provider is paid the negotiated unit rate. If fewer than three services are provided, there is no payment. Model outcomes to date and data sharing are listed below:

- **Number of individuals served**. Initial total participant slots in the program were capped at 300 individuals. The cap has been increased to permit up to 600 individuals to enroll.
- **Service utilization and expenditure information**. The state has collected and evaluated Medicaid claims data for ACIS participants during the period of July 2017-July 2018.
- **Description of any data sharing across systems**. The state is looking primarily at Medicaid claims data and is trying to integrate housing status data from the Homeless Management Information System data.

Evaluation methods and information on outcomes. Maryland is conducting an evaluation of its section 1115 demonstration using Medicaid claims data for the period of July 2017-July 2018. Maryland's program evaluation will examine housing tenure impact, diversion from the justice system, service utilization and cost savings, and impact on health conditions. The proposed Assistance in Community Integration Services evaluation design specifies the following measures to determine if the pilot improves participant health outcomes: (1) pre- and post-living situation; (2) Emergency Department visits; (3) inpatient admissions; (4) HEDIS measure for follow-up after hospitalization for mental illness; and (5) frequency of admissions to 24 CFR 578.3 facilities.[200]

Partnerships employed to manage and coordinate projects.

Medicaid managed care organizations. The state Medicaid agency contracts with the state's Medicaid MCOs and each jurisdiction participating in ACIS is required to work with the relevant MCOs for the individuals enrolled in their specific pilot.

Lead Entities. Any local governmental entity is eligible to serve as a "Lead Entity" under Maryland's ACIS Pilot. The Maryland Department of Health pays the pilot lead entities

for demonstration services at a negotiated per member, per month rate as described in the approved demonstration protocol.[201]

- **Health systems and hospitals.** This varies by jurisdiction; Baltimore City recently secured a $2 million total local matching fund commitment for ACIS from a consortium comprised of every hospital in the Baltimore City area.
- **State and local housing agencies.** The state Medicaid agency did not have a formal partnership with state or local housing agencies specific to Assistance in Community Integration Services but worked together with the state behavioral health and housing agencies informally to provide technical assistance during the design of the competitive application for the pilots and throughout the implementation period. Other partnerships that exist related to the Assistance in Community Integration Services pilots are jurisdiction-specific.
- **FQHC Health Care for the Homeless programs.** This also varies by jurisdiction; the FQHC/Health Care for the Homeless grantee in Baltimore City is the sole provider for Baltimore City to Assistance in Community Integration Services participants, although primary care is not a component of Assistance in Community Integration Services.
- **Other care coordination providers.** The pilots were required to coordinate, as appropriate, based on the population served.
- **Other partnerships.** The state partnered with the state health department to disseminate information to local health departments that would be applying to implement the Assistance in Community Integration Services program.

d. Philadelphia, Pennsylvania—Community Behavioral Health/Pathways to Housing

Goals and objectives for housing supports, specific to the population with a substance use disorder. Under the Pennsylvania Health Choices section 1915(b) program, counties are responsible for contracting with managed care organizations (MCOs) to administer mental health and drug and alcohol services to Medicaid enrollees. Community Behavioral Health is the MCO contracted by the City of Philadelphia's Department of Behavioral Health and Intellectual DisAbility Services to administer these services to Philadelphia County Medicaid recipients. The Department of Behavioral Health and Intellectual DisAbility Services works in partnership with the City Office of Homeless Services' Supportive Housing Clearinghouse to assess and prioritize individuals with a mental disorder, a substance use disorder (SUD), or both who are experiencing homelessness for short-term and permanent housing subsidies.

Community Behavioral Health's Community Support Services team works to ensure access to service packages that can support individuals' housing transition and stabilization, with the goal of improving housing tenure and health, and promoting wellness and recovery, community inclusion, and increased income. Services may include both Medicaid state plan services (e.g., targeted case management and rehabilitative services including peer supports) and services funded through Medicaid savings achieved by the MCO that cover state-approved supplemental services (Behavioral Health Special Initiative intensive case management, ACT, mobile psychiatric rehabilitation, and drug and alcohol services that are not available in the Medicaid fee-for-service [FFS] program).[202] Medicaid reimbursement is a mix of negotiated per diem rates and standard FFS rates set by Community Behavioral Health. Annual performance payments are available to agencies that meet certain benchmarks, such as rate of stable discharges and continuity of care. Additional components such as case management also will be moving to a value-based payment system over the next year.

Although the City emphasizes permanent housing for individuals with a behavioral health disorder who are experiencing homelessness, a continuum of options has been developed for those who may want recovery or treatment supports prior to entering permanent housing. For example, the Journey of Hope program, a collaboration between the Department of Behavioral Health and Intellectual DisAbility Services, Homeless Services, and the Office of Addiction Services, transformed several SUD residential treatment programs to engage individuals

experiencing chronic homelessness with SUD, including those with co-occurring mental illness. Individuals are offered treatment services ranging from 6 months to a year, followed by connection to supportive housing opportunities, as well as on-going outreach and follow-up to help support long-term sustained recovery in the community. The Office of Addiction Services also funds several recovery houses across the City that serve the non-chronically homeless segment of the target population. About a third of the City's approximately 1,500 permanent supportive housing beds funded through the U.S. Department of Housing and Urban Development (HUD)'s CoC program and dedicated to individuals experiencing chronic homelessness are operated using fidelity to the Housing First model. One permanent supportive housing provider with an established history of serving individuals with mental illness and co-occurring SUD—Pathways to Housing PA—has been focused primarily for the past 2 years on operating Housing First permanent supportive housing targeted specifically to individuals with OUD)/SUD as explored further below.

Target population. Pathways to Housing PA primarily serves individuals experiencing chronic homelessness who have OUD/SUD. About 80 percent also have mental illness, but SUD is the primary presenting condition upon engagement in services.

Geographic focus. Pathways to Housing PA operates across the City of Philadelphia.

Model overview. Pathways to Housing PA provides scattered site permanent supportive housing using a Housing First and harm reduction approach. The organization uses a combination of federal (HUD CoC and housing authority vouchers) and locally funded rental assistance (City general funds) to serve the target population. Pathways has a housing department within the agency that works with landlords to secure rental units for program participants using local funds. Housing-related services are provided using two ACT-like (blended enhanced targeted case management) teams that incorporate peer specialists and recovery coaches and deliver many Medicaid-funded individual housing transition and tenancy sustaining services. Participants also are linked to other Community Behavioral Health-covered services for its Medicaid beneficiaries. All individuals are offered medication-assisted treatment (MAT) funded with Substance Abuse and Mental Health Services Administration (SAMHSA) grant and state funds when clinically indicated. Additionally, all participants are equipped with naloxone and have developed overdose prevention goal plans with their case management team. Individuals are referred by the Department of Behavioral Health and Intellectual DisAbility Services and are

located through street outreach teams funded with City general funds, shelters, and/or safe havens.

Additionally, the City's network of recovery houses offers an alcohol and drug-free transitional housing alternative in 27 properties that serve 470 individuals at any given time. Individuals in these settings are paired with outpatient treatment, 24/7 on-site staffing, and case management services that work to assist individuals in transitioning to permanent housing. Model outcomes to date and data sharing are listed below:

- **Number of individuals served.** Currently, 135 individuals are engaged in Pathways services with capacity to serve 150.
- **Service utilization and expenditure information.** Of those housed by Pathways, 72 percent are receiving MAT and 94 percent have basic engagement with psychiatry, having seen a psychiatrist within the past year, whereas 22 percent are engaged in more ongoing treatment by a psychiatrist.
- **Description of any data sharing across systems.** Community Behavioral Health noted that it is working across systems to look at both housing and health plan data to target those experiencing homelessness with OUD/SUD. Community Behavioral Health staff members use their data systems to track housing stability, service utilization, and costs through both Medicaid claims and the Homeless Management Information System data.
- **Evaluation methods and information on outcomes.** The Department of Behavioral Health and Intellectual DisAbility Services and Office of Homeless Services partnership has resulted in a 97 percent success rate in preventing a return to homelessness for families served in permanent supportive housing and an 88 percent to 91 percent success rate for individuals. Pathways to Housing reported that it has a 96 percent housing retention rate with 113 of their individuals who have been housed. The program tracks required HUD CoC performance measures related to housing, income, and tenancy. It also tracks health-related outcomes required by specific grants and for independent studies of their program.

Partnerships employed to manage and coordinate projects.

- **Medicaid managed care organizations.** Community Behavioral Health is the behavioral health MCO for Philadelphia.

- **Health systems and hospitals.** Community Behavioral Health contracts with area hospital and crisis response centers to ensure that they have access to the full array of housing options and related supports for the eligible individuals they serve. Pathways has a partnership with a local hospital whereby it has purchased the services of one of its primary care doctors half a day per week to serve Pathways clients.
- **State and local housing agencies.** Community Behavioral Health works directly with the City's Office of Homeless Services, the Philadelphia Public Housing Authority, and the Pennsylvania Housing Finance Agency. Pathways to Housing has worked to secure rental subsidies from the City of Philadelphia for those it serves with OUD.
- **Federally Qualified Health Centers (FQHCs) Health Care for the Homeless programs.** Community Behavioral Health and Pathways work with area FQHCs to ensure that program participants receive comprehensive and coordinated integrated care. Community Behavioral Health contracts with every FQHC, embedding behavioral health workers into these centers along with the look-alike community health clinics. Pathways works with a satellite FQHC to access MAT for its clients as well.
- **Other care coordination providers.** Community Behavioral Health works closely with the area's entire continuum of alcohol and drug treatment providers to ensure coordination of comprehensive care for MCO enrollees, including those engaged in permanent supportive housing.

e. Washington Foundational Community Supports/Yakima Neighborhood Health Services

Goals and objectives for housing supports, specific to the population with a substance use disorder. Washington's approved section 1115 demonstration authorizes the provision of Foundational Community Supports, which have been offered since January 2018 and include both housing-related and supported-employment services. The intended goals of the demonstration are to integrate behavioral health into the larger health care system and to address housing and employment needs as social determinants of health. The aim is to improve health outcomes and reduce unnecessary utilization of high-cost health care services such as emergency department visits and inpatient bed stays.

Target population. The target population for Foundational Community Supports supportive housing services is inclusive of but not specifically targeted to individuals with an SUD who are experiencing or are at risk of experiencing homelessness. Eligibility includes individuals at least 18 years of age who are eligible for Medicaid and meet criteria related to individually assessed need for at least one of the following: (1) treatment for mental illness, (2) substance use disorder (SUD) treatment, (3) assistance with activities of daily living, or (4) treatment for a complex physical health need. Individuals also must have at least one of the following risk factors: chronic homelessness (as defined by the U.S. Department of Housing and Urban Development), frequent or lengthy institutional contacts, frequent or lengthy residential care stays (including in SUD treatment), frequent turnover of in-home caregivers, or an elevated Predictive Risk Intelligence System (PRISM) risk score of 1.5 or above.

During the first year of service delivery, more than 70 percent of those enrolled in supportive housing services identified a SUD-related treatment need in the past 24 months. Data indicate that most of those enrolled with SUD have a co-occurring mental disorder (72 percent needing both mental health and SUD services in the past 24 months). Individuals experiencing chronic homelessness represent approximately 26 percent of those enrolled in supportive housing services. Although the potential for overlap between those with SUD who also are homeless or at risk of homelessness is high, the state has not examined data specific to this population to date.

Geographic focus. Foundational Community Supports supportive housing services are available statewide. The third-party administrator, Amerigroup, has certified a network of more than 108 agencies in 300 sites to provide services in both rural and urban areas. One reported

deterrent to becoming a Foundational Community Supports provider is the lack of available affordable housing stock and rent subsidies for those who could benefit from these services.

One of the state's providers, Yakima Neighborhood Health Services, is an FQHC that also operates a Health Care for the Homeless program and provides health care to 24,000 patients in Yakima County. Challenges to enrolling and serving individuals in the target population in Foundational Community Supports services noted by this rural provider include the need for prolonged outreach in outdoor areas such as fields located well outside of towns; limited housing availability; and lack of available transportation, in addition to the remoteness of the closest residential SUD treatment provider—a 3-hour bus ride away. The state is creating a Tableau® map to let individuals and referral sources find Foundational Community Supports providers and ascertain whether they are accepting external referrals and coverage in every county across the state.

Community Support Services (Supportive Housing Services) Model Overview. Both Housing First and recovery housing options are available on the basis of individual preference and the availability of these options in each community. Housing is located in both site-based/congregate and scattered site settings and is primarily permanent, although transitional housing sometimes is used because of the state's affordable housing crisis. The Foundational Community Supports Community Support Services (CSS) supportive housing services benefit is fairly comprehensive and includes many Medicaid-funded individual housing transition and tenancy sustaining services, although move-in costs are covered by non-Medicaid resources. Foundational Community Supports providers are encouraged to coordinate services with their local behavioral health, health care, and homeless service systems.

The section 1115 demonstration has facilitated structural redesign whereby the state's Division of Behavioral Health and Recovery now is integrated with the Health Care Authority (HCA) where the Medicaid program is located, further promoting local integration efforts. Foundational Community Supports is interconnected with activities and services funded by the Substance Abuse and Mental Health Services Administration's (SAMHSA's) State Targeted Response to the Opioid Crisis and State Opioid Response grants, and communities are coordinating these and other federal and local resources, such as SAMHSA Projects for Assistance in Transition from Homelessness, Health Resources and Services Administration FQHC/Health Care for the Homeless funds, deed recording fees, and other local funds, to cover

the cost of outreach and engagement to the target population. Medicaid reimbursement to Amerigroup is a combination of fee for service (FFS) and per member per month based on the number enrolled. Amerigroup then reimburses providers on a FFS basis. Model outcomes to date and data shared are listed below:

- **Number of individuals served.** As of April 2019, 2,207 individuals were enrolled in the Foundational Community Supports supportive housing benefit, with 472 of those co-enrolled in supported employment services. The state has projected its capacity to serve up to 4,500 and 3,500 individuals per month in supportive housing and supported employment services, respectively.
- **Service utilization and expenditure information.** As of November 2018, the most recent month for which service utilization data are available, 49 percent of enrollees received only mental health services, 5 percent received only SUD services, and 29 percent received both mental health and SUD services within the prior 12-month period.
- **Description of any data sharing across systems.** Washington is a leader in using integrated client administrative data from multiple systems to inform decisions as to whom to target for these services and the associated costs. PRISM, which is a factor in Foundational Community Supports eligibility, is a predictive tool that uses the International Classification of Diseases, Tenth Revision (ICD-10) to identify Medicaid beneficiaries at risk of high service utilization and expenditures.
- **Evaluation methods and information on outcomes.** Washington is conducting an evaluation of its section 1115 demonstration; although, no data are yet available beyond basic information on enrollees (e.g., demographics, numbers enrolled). Intended Foundational Community Supports program outcomes include (1) an overall increase in health measures, (2) improved employment statistics, (3) more stable living situations and a reduction in the use of intensive services, (4) significant cost savings, and (5) healthier people and stronger communities.

Partnerships employed to manage and coordinate projects.

- **Medicaid managed care organizations.** Amerigroup, the third-party administrator, is very involved. Other managed care organizations are interested in the Foundational

Community Supports initiative but are waiting for program outcomes to determine their approaches to implementing follow-on supports.

- **Health systems and hospitals.** The Washington HCA has been working to educate the Washington Hospital Association about the value of housing paired with housing-related services on their patient populations and has made technical assistance available to them in the past calendar year by providing two webinars. The state planning around expanding the scale of Foundational Community Supports services includes future work to educate hospital systems about the importance of these benefits in improving health outcomes.
- **Accountable care organizations.** Washington's section 1115 demonstration included the creation of nine Accountable Communities of Health that bring together leaders from multiple health sectors to fund Medicaid transformation projects focused on health systems capacity building, care delivery redesign, prevention and health promotion, and increased use of value-based payment models. As with the Washington State Hospital Association, the HCA has been working to educate the Accountable Communities of Health about the value of housing paired with housing-related services and provided technical assistance in the past calendar year by providing two webinars and a presentation at the Accountable Communities of Health State Conference. The state planning related to expanding the scale of Foundational Community Supports services includes future work to educate Accountable Communities of Health about the importance of these benefits in improving health outcomes and promoting whole person care.
- **State and local housing agencies.** HCA has established partnerships with state-level housing agencies such as the Department of Commerce, which oversees some behavioral health housing, operates a landlord mitigation program, and administers several state and federal funding sources that support homeless programs statewide. HCA also works with different local public housing authorities and has presented on the Foundational Community Supports program to the Public Housing Authority Association and Community Action Council Association.
- **Federally Qualified Health Centers (FQHC) Health Care for the Homeless programs.** As noted above, Yakima Neighborhood Health Services is a Foundational

Community Supports provider of supportive housing and supported employment services, as well as an FQHC and Health Care for the Homeless program grantee. All individuals served by this provider in Foundational Community Supports are either exiting or are at risk of homelessness; 30 percent have at least one or more drug or alcohol conditions. Other communities such as Seattle have Foundational Community Supports providers that also are FQHC and/or Health Care for the Homeless providers.

- **Other care coordination providers.** Other care coordination providers' work with SAMHSA Projects for Assistance in Transition from Homelessness outreach teams to expand the reach of what the teams can do.
- **Other partnerships.** The recent integration of the state Division of Behavioral Health and Recovery with the state HCA, which houses the Medicaid agency, has facilitated state-level integration.

APPENDIX B: Federal Programs to Support the Continuum of Housing Options for Individuals with Substance Use Disorder

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), recovery, being unique to each person, warrants a range of housing options for people, whether they are transitioning from homelessness, a treatment facility, or even their own home. Although a continuum of affordable housing models is critical in the recovery process to address the unique needs of individuals with SUD,[203] federal financial participation is not available to state Medicaid programs for room and board (except in certain medical institutions).[204] Further, federal financial participation is not available for the acquisition, construction, or operational (including ongoing rent and utilities) costs of the affordable housing programs discussed in this report.

Affordable housing models or programs that include a supportive services component for individuals with SUD who are experiencing homelessness or who are at risk of experiencing homelessness are largely funded by the U.S. Department of Housing and Urban Development's (HUD's) homeless assistance resources made available through the Continuum of Care (CoC) and Emergency Solutions Grant (ESG) programs.[205] Other forms of federal rental assistance for which individuals with SUD who are homeless or at risk of homelessness may be eligible include HUD's Housing Choice Voucher and Veterans Affairs Supportive Housing (HUD-VASH) programs.[206,207] Programs such as HUD's Mainstream Voucher and section 811 programs require a primary qualifying disability other than SUD.[208,209] Many states and local jurisdictions set aside resources from general funds, bonds, or levies to fund rental assistance. For example, the majority of states have some type of state-funded rental assistance program designed to meet the needs of a specific target population, with many state behavioral health agencies administering tenant-based rental assistance to meet the affordable housing needs of low-income individuals with mental illness, SUD, or other disabilities, as well as those experiencing or are at risk of homelessness. State-funded rental assistance programs are often intended to be a temporary "bridge" to more permanent, federally subsidized rental assistance.[210]

Affordable housing models or programs for individuals with SUD who are experiencing or are at risk of experiencing homelessness will vary depending on where a person is in his or her recovery process. An individual who is experiencing chronic homelessness may need housing with access to more intensive services. Some individuals may prefer sober or recovery housing,

and others may need rental assistance to afford independent community-based housing.[211] Affordable housing approaches to address the housing needs of individuals with SUD include supportive housing, transitional housing, recovery housing, and rental assistance made available either during a person's recovery process or after inpatient treatment. These housing options are described in the following paragraphs.

Supportive housing combines affordable housing with access to voluntary services and supports to help people with chronic physical and behavioral health issues maintain stable housing and access health and social supports.[212] SAMHSA has categorized supportive housing services as services to support housing retention, independent living skills, recovery-focused services, community integration services, mental health services, health and medical services, substance use services, vocational and employment services, and family services.[213]

Housing First is a form of the evidence-based permanent supportive housing model that has been found to be effective at achieving housing stability among individuals with serious mental health disorders and among individuals experiencing chronic homelessness, including those with primary and co-occurring SUD.[214] The model pairs permanent lease-based housing with intensive case management services using a low-barrier admission policy, meaning there are no conditions on tenancy such as sobriety or treatment participation. Housing units may be scattered site, rent-subsidized apartments leased in the open market, or site based, with units integrated within affordable housing properties that partially or exclusively serve individuals needing permanent supportive housing. Services are offered on a voluntary basis in community-based, rather than clinic-based, settings using assertive engagement strategies to assist clients in retaining housing and accessing the range of treatment and supports needed to stabilize and improve their health and recovery.[215] High-quality Housing First programs have been shown to improve housing tenure and reduce high-cost service use among individuals experiencing homelessness with the most complex needs.[216]

Several federal agencies recognizing supportive housing as a best practice have aligned policies and programs with the Supreme Court's Olmstead decision (1999), which upheld Title II of the Americans with Disabilities Act and the right of individuals with disabilities to live in the least restrictive, most integrated setting possible. The decision requires states to plan affirmatively to serve people in integrated, community-based settings. Since that decision, many states have worked to transition from institutionally based systems of care (e.g., residential care

homes, and adult care homes) to more integrated community-based models such as supportive housing.[217] The principles laid out in SAMHSA's permanent supportive housing Toolkit, a Department of Justice statement on community integration, a HUD Olmstead statement, and the Centers for Medicare & Medicaid Services (CMS) final rule on home and community-based services all serve to align these agencies' policies on integrated and segregated settings, individual choice, and person-centered planning.[218]

Some individuals with SUD who are in a recovery process may choose an abstinence-focused residential or housing program in a sober community, often referred to as either recovery housing, sober housing, Oxford housing, or residential treatment housing.[219] SAMHSA defines recovery housing as "safe, healthy, family-like substance-free living environments that support individuals in recovery from addiction. While recovery residences vary widely in structure, all are centered on peer support and a connection to services that promote long-term recovery. Recovery housing benefits individuals in recovery by reinforcing a substance-free lifestyle and providing direct connections to other peers in recovery, mutual support groups and recovery support services. Substance-free does not prohibit prescribed medications taken as directed by a licensed prescriber, such as pharmacotherapies specifically approved by the Food and Drug Administration (FDA) for treatment of opioid use disorder as well as other medications with FDA-approved indications for the treatment of co-occurring disorders."[220] Some studies have found that recovery housing can improve the likelihood that individuals with SUD will achieve long-term recovery,[221] be cost-effective,[222] and result in decreased rates of substance use and incarceration and higher monthly incomes.[223] Central City Concern, a nonprofit organization in Portland, Oregon, has developed an innovative recovery housing model called "Housing Choice" offering a range of both short-term and long-term housing options to optimize individual housing choice based on personal need.[224]

For those who do not have co-occurring disabling conditions or lengthy, repeated homeless episodes, transitional housing with targeted and time-limited supports may be sufficient to assist individuals in achieving long-term recovery. HUD-funded transitional housing programs provide people experiencing homelessness with a place to stay combined with supportive services for up to 24 months.[225]

Rental assistance programs can help individuals afford to live independently in the community in housing of their choice during different stages of recovery, such as after

completing inpatient treatment or to avert a housing crisis during an employment disruption. Rapid re-housing emphasizes housing search and relocation services and short-term rental assistance to move individuals experiencing homelessness and families (with or without a disability) as rapidly as possible into permanent housing. Other federally funded rental assistance programs provide housing choice through privately owned subsidized housing, public housing, and housing choice voucher programs.[226]

Many individuals with SUD who are experiencing homelessness transition into Housing First/supportive housing and/or recovery housing programs from the streets, shelters, places not meant for human habitation, detoxification facilities or medical respite units, or post-discharge after short stays in inpatient hospitals or SUD inpatient/residential treatment facilities. In 2017, HUD issued additional guidance to CoC entities receiving federal homeless assistance resources requiring the establishment of Coordinated Entry Systems to ensure that individuals experiencing homelessness with the greatest vulnerability and need receive priority access to housing and supports available through local homeless response systems. While each community's Coordinated Entry System operates differently and cannot make decisions based on a specific disability, HUD's guidance[227] allows CoCs to use a combination of factors such as physical and behavioral health conditions and high utilization of crisis or emergency services, to determine vulnerability and make prioritization decisions, making it more likely that individuals with SUD who are experiencing homelessness could be prioritized for these resources.

Housing First/supportive housing and recovery housing programs that are not funded with federal homeless assistance resources typically have their own eligibility criteria and referral/prioritization processes tailored to the specific needs of the populations intended to be served. Those specifically designed to serve individuals with SUD who are experiencing or at risk of experiencing homelessness tend to screen in and prioritize those who are high utilizers of services such as emergency departments, detoxification centers, medical respite, and inpatient beds and also often have frequent contact with shelters, jails, police/emergency responders, and other public systems. Some programs/initiatives are designed to serve a subset of those with SUD who are experiencing or at risk of homelessness, such as families involved with the child welfare system, transition-aged youth, and/or those exiting the criminal justice system.

SAMHSA grant funding has been a catalyst for supportive housing models or programs for individuals with SUD who are experiencing or are at risk of experiencing homelessness,

meeting needs depending on where a person is in their recovery process. SAMHSA's Substance Abuse Prevention and Treatment Block Grant gives states the flexibility to make loans for the costs of establishing programs for the provision of housing in which individuals recovering from a SUD may reside in groups of not less than six individuals.[228] Further, SAMHSA funds Projects for Assistance in Transition from Homelessness to states that oversee local public or nonprofit organizations that provide a variety of essential services to individuals who have serious mental illnesses, may have co-occurring SUDs, and are experiencing homelessness or are at imminent risk of homelessness.

APPENDIX C: Challenges to Accessing the Continuum of Housing Options for Individuals with Substance Use Disorder

In many communities, federal, state, and local funding and the supply of housing stock to address the continuum of housing needs for low-income households is not sufficient. For instance, federal housing assistance is a limited resource that serves just one out of every four very low-income renter households. For households that qualify for federal housing assistance, several challenges persist in finding and securing affordable housing. Wait times for Department of Housing and Urban Development (HUD) subsidies averaged 27 months in 2017, ranging from about 18 months for public housing to 32 months for vouchers. Many cities have closed their waiting lists for both of these types of assistance. Housing choice voucher-use success rates are also generally low because of challenges with finding eligible housing in the private market and difficulty renting appropriate housing, because landlords in many cities can refuse to accept vouchers.[229]

Individuals with SUD face unique barriers to federal housing assistance. Individuals with SUD who are experiencing homelessness may have difficulty obtaining documents required for determining eligibility for housing programs, such as birth certificates and Social Security cards; difficulty with navigating housing application, eligibility, and housing search efforts; lack of income supports; and limited transportation options. Additional barriers include federal statutory requirements that impose time-limited bans against living in HUD-assisted housing for people evicted for drug-related activities and policies that allow housing agencies to prohibit people who have histories of past drug use or are considered at risk of engaging in illegal drug use from receiving assistance.[230] Further, homeless services providers and housing providers may prohibit individuals who take medications for opioid use disorder to participate in shelter or housing programs.[231]

APPENDIX D: Glossary

42 CFR Part 2: 42 CFR Part 2 contains the federal regulations on Confidentiality of Substance Use Disorder Patient Records. The regulations established privacy and confidentiality requirements for Part 2 program information regarding individuals' diagnosis or treatment for substance use disorder (SUD). These requirements, which govern substance use disorder patient records, are more restrictive than the HIPAA standards for personal health information.[232]

Accountable Health Communities Model: The Accountable Health Communities Model, a CMS Innovation Center initiative, "addresses a critical gap between clinical care and community services in the current health care delivery system by testing whether systematically identifying and addressing the health-related social needs of Medicare and Medicaid beneficiaries' through screening, referral, and community navigation services will impact health care costs and reduce health care utilization."[233]

Annual Homeless Assessment Report: The Annual Homeless Assessment Report is a U.S. Department of Housing and Urban Development (HUD) "report to the U.S. Congress that provides nationwide estimates of homelessness, including information about the demographic characteristics of homeless persons, service use patterns, and the capacity to house homeless persons. The report is based on Homeless Management Information Systems (HMIS) data about persons who experience homelessness during a 12-month period, point-in-time counts of people experiencing homelessness on one day in January, and data about the inventory of shelter and housing available in a community."[234]

At-risk of homelessness: HUD regulations (24 CFR § 91.5) define ***at risk of homelessness*** as follows:

"(1) An individual or family who:

(i) Has an annual income below 30 percent of median family income for the area, as determined by HUD;

(ii) Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the "Homeless" definition in this section; and

(iii) Meets one of the following conditions:

(A) Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance; (B) Is living in the home of another because of economic hardship; (C) Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance; (D) Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals; (E) Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau; (F) Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or (G) Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

(2) A child or youth who does not qualify as "homeless" under section [24 CFR § 91.5], but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

(3) A child or youth who does not qualify as "homeless" under section [24 CFR § 91.5], but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him."[235]

Beneficiary: 42 CFR § 435.4 defines a beneficiary as "an individual who has been determined eligible and is currently receiving Medicaid."[236]

Birth Cohort Effect: "Data from three decennial censuses have revealed that contemporary homelessness among single adults is concentrated among persons born in the latter half of the post-War baby boom (1955-1965) and in the years immediately adjacent to that period. Demographers refer to this as a "cohort effect," or more specifically an "Easterlin cohort effect," named after the demographer Richard Easterlin. Easterlin hypothesized that individuals born after the peak of a baby boom are more likely to be economically disadvantaged relative to their predecessors due to an excess supply of workers at the time of their labor market entry, among other factors."[237]

By-Name List: Also called a 'master list' or 'active list', a By-Name List "is a real-time, up-to-date list of all people experiencing homelessness which can be filtered by categories and shared across agencies." This list is generated by HUD-funded local homeless Continuums of Care (CoCs) with information from HMIS data and community agencies who work with individuals experiencing homelessness. "This tool allows communities to know every person experiencing homelessness by name, in real time without having to wait for a [Point-In-Time] count. A By-Name List also facilitates community decisions on how to identify the needs of each person, target those who may be eligible for various programs, and prioritize people who are most in need of housing and services."[238]

Chronic Homeless Policy Academy: Between 2001 and 2006, the U.S. Department of Health and Human Services partnered with HUD, the U.S. Veterans Health Administration, the U.S. Interagency Council on Homelessness, the U.S. Department of Labor, and the U.S. Department of Education to fund five *Homeless Policy Academies* focused on chronic homelessness that were designed to bring together state-level program administrators and homeless service providers in order to develop state-specific action plans designed to increase access to mainstream resources for persons experiencing chronic homelessness. The U.S. Department of Health and Human Services, along with their federal partners, provided significant technical assistance resources to participating jurisdictions to assist them in the implementation of their Policy Academy action plans.[239]

Chronically homeless: HUD defines a "chronically homeless'' individual at 24 CFR Parts 91 and 578 to mean a homeless individual with a disability who lives either in a place not meant for

human habitation, a safe haven, or in an emergency shelter, or in an institutional care facility if the individual has been living in the facility for fewer than 90 days and had been living in a place not meant for human habitation, a safe haven, or in an emergency shelter immediately before entering the institutional care facility. In order to meet the ''chronically homeless'' definition, the individual also must have been living as described above continuously for at least 12 months, or on at least four separate occasions in the last 3 years, where the combined occasions total a length of time of at least 12 months. Each period separating the occasions must include at least 7 nights of living in a situation other than a place not meant for human habitation, in an emergency shelter, or in a safe haven.[240] A "homeless individual with a disability," as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), includes an individual who has SUD.

Comparability: Section 1902(a)(10)(B) of the Social Security Act, 42 U.S.C. § 1396a(a)(10)(B), requires that a Medicaid-covered benefit generally must be provided in the same "amount, duration, and scope" to all enrollees. Waivers of comparability allow states to limit a benefit package to a targeted group of persons identified as needing it most and/or to limit the number of participants to implement a demonstration on a smaller scale.[241]

Co-occurring disorders: The coexistence of both a mental health and a substance use disorder is referred to as co-occurring disorders. Although people may have a number of health conditions that co-occur, including physical problems, the term "co-occurring disorders," in this report, refers to substance use and mental health disorders.[242]

Continuum of Care (CoC): The HUD CoC Program is designed to "promote community-wide commitment to the goal of ending homelessness; provide funding for efforts by nonprofit providers, and state and local governments to quickly rehouse homeless individuals and families while minimizing the trauma and dislocation caused to homeless individuals, families, and communities by homelessness; promote access to and effect utilization of mainstream programs by homeless individuals and families; and optimize self-sufficiency among individuals and families experiencing homelessness."[243]

Freedom of choice: Section 1902(a)(23) of the Social Security Act, 42 USC § 1396a(a)(23), provides that all Medicaid beneficiaries must be permitted to choose a qualified health care provider from among any of those participating in Medicaid. Freedom of choice waivers are

typically used to allow implementation of managed care programs or to otherwise restrict the pool of providers authorized to deliver services.[244]

Frequent Users Systems Engagement (FUSE) model: The FUSE model, which is used by locally-funded initiatives, identifies frequent users of jails, shelters, hospitals and/or other crisis public services and then aims to improve their lives through supportive housing.[245]

Harm reduction: "Harm reduction is a pragmatic approach to reduce the harmful consequences of drug use and other high-risk activities by incorporating several strategies that cut across the spectrum from safer use to managed use to abstinence. The primary goal of most harm-reduction approaches is to meet individuals where they are at and not to ignore or condemn the harmful behaviors, but rather to work with the individual or community to minimize the harmful effects of a given behavior. Harm-reduction interventions and policies are most often individualized to the specific needs and wants of the individual or community; thus, a universal harm-reduction program is not possible and would not be useful." Some examples of harm reduction approaches include needle exchange programs, safe injection facilities, and overdose reversal medication.[246]

Healthcare Hot Spotting: The Camden Coalition defines "healthcare hot spotting" as strategic use of data to reallocate resources to a small subset of high-need, high-cost patients. They use "data to discover the outliers, understand the problem, dedicate resources, and design effective interventions."[247]

Health Care for the Homeless: The Public Health Service Act, section 330(h), 42 USC 254b(h), provides that the U.S. Department of Health and Human Services, Health Resources Services Administration may award grants "for the planning and delivery of services to a special medically underserved population comprised of homeless individuals, including grants for innovative programs that provide outreach and comprehensive primary health services to homeless children and youth, children and youth at risk of homelessness, homeless veterans, and veterans at risk of homelessness." Section 330(h)(2) further provides that "in addition to required primary health services, an entity that receives a grant under this subsection is required to provide substance abuse services as a condition of such grant."[248] For a list of the more than 200 Health Care for the Homeless grantees see: https://nhchc.org/directory/.

Home & Community Based Services (HCBS): HCBS "provide opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions. These programs serve a variety of targeted populations groups, such as people with intellectual or developmental disabilities, physical disabilities," mental illness and SUDs.[249]

Homeless: Regulations promulgated by HUD at 24 CFR § 91.5 under the Homeless Emergency Assistance and Rapid Transition to Housing Act of 2009 (HEARTH Act) define ***homeless*** as follows:

> "(1) An individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: (i) An individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground; (ii) An individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low-income individuals); or (iii) An individual who is exiting an institution where he or she resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution;
> (2) An individual or family who will imminently lose their primary nighttime residence, provided that: (i) The primary nighttime residence will be lost within 14 days of the date of application for homeless assistance; (ii) No subsequent residence has been identified; and (iii) The individual or family lacks the resources or support networks, e.g., family, friends, faith-based or other social networks, needed to obtain other permanent housing;
> (3) Unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition, but who: (i) Are defined as homeless under section 387 of the Runaway and Homeless Youth Act (42 U.S.C. 5732a), section 637 of the Head Start Act (42 U.S.C. 9832), section 41403 of the Violence Against Women Act of 1994 (42 U.S.C. 14043e–2), section 330(h) of the Public Health Service Act (42 U.S.C. 254b(h)), section 3 of the Food and Nutrition Act of 2008 (7 U.S.C. 2012), section 17(b) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)), or section 725 of the McKinney-Vento Homeless Assistance Act (42 U.S.C.

11434a); (ii) Have not had a lease, ownership interest, or occupancy agreement in permanent housing at any time during the 60 days immediately preceding the date of application for homeless assistance; (iii) Have experienced persistent instability as measured by two moves or more during the 60-day period immediately preceding the date of applying for homeless assistance; and (iv) Can be expected to continue in such status for an extended period of time because of chronic disabilities, chronic physical health or mental health conditions, substance addiction, histories of domestic violence or childhood abuse including neglect), the presence of a child or youth with a disability, or two or more barriers to employment, which include the lack of a high school degree or General Education Development (GED), illiteracy, low English proficiency, a history of incarceration or detention for criminal activity, and a history of unstable employment; or (4) Any individual or family who: (i) Is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has either taken place within the individual's or family's primary nighttime residence or has made the individual or family afraid to return to their primary nighttime residence; (ii) Has no other residence; and (iii) Lacks the resources or support networks, e.g., family, friends, faith-based or other social networks, to obtain other permanent housing."[250]

Homeless individual: For purposes of regulating health centers, the Public Health Service Act at § 330(h), 42 USC § 254b(h)(5)(A), defines a ***homeless individual*** as "an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations and an individual who is a resident in transitional housing."[251]

Homelessness Management Information System (HMIS): "A [HMIS] is a HUD-funded local information technology system used to collect client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness. Each HUD-funded CoC is responsible for selecting an HMIS software solution that complies with HUD's data collection, management, and reporting standards."[252]

Housing choice voucher program: "The housing choice voucher program is the federal government's major program for assisting very low-income families, the elderly, and the disabled to afford decent, safe, and sanitary housing in the private market. Since housing assistance is provided on behalf of the family or individual, participants are able to find their own housing, including single-family homes, townhouses, and apartments. The participant is free to choose any housing that meets the requirements of the program and is not limited to units located in subsidized housing projects. Housing choice vouchers are administered locally by [public housing agencies]."[253]

Housing First: Housing First is an evidence-based practice recognized by HUD and SAMHSA that has been defined by HUD as an approach used "to quickly and successfully connect individuals and families experiencing homelessness to permanent housing without preconditions and barriers to entry, such as sobriety, treatment, or service participation requirements. Supportive services are offered to maximize housing stability and prevent returns to homelessness as opposed to addressing predetermined treatment goals prior to permanent housing entry."[254]

Managed care organization (MCO): A managed care organization (MCO) is a type of managed care plan that has a risk contract to provide comprehensive Medicaid state plan services and meets certain requirements under section 1903(m) of the Act and 42 C.F.R. Part 438. MCOs are paid a set actuarially sound per member per month capitation rate for furnishing these services.

Measure H: A sales tax measure to fund homeless services and prevention in Los Angeles County, California that passed on March 7, 2017. The specific services and programs to be funded by Measure H comply with the "Approved Strategies to Combat Homelessness" drafted by the Los Angeles County Homeless Initiative (HI) and approved by the county board of supervisors on February 9, 2016. Measure H is projected to generate $355 million annually over ten years to fund key HI strategies. Most of these funds are to be used for rental subsidies, support services for households placed in permanent housing, outreach and in-reach, and enhancement of the County's shelter system.[255]

Medicaid Innovation Accelerator Program (IAP): The IAP is a collaboration between the Center for Medicaid and CHIP Services (CMCS) and the CMS Center for Medicare & Medicaid

Innovation. The goal of IAP is to improve the health and health care of Medicaid beneficiaries and to reduce costs by supporting states' ongoing payment and delivery system reforms. Medicaid IAP supports state Medicaid agencies to build capacity in key program and functional areas by offering targeted technical support, tool development, and cross-state learning opportunities. IAP selected, in consultation with states and stakeholders, four program areas in which to offer technical support: reducing SUDs; improving care for Medicaid beneficiaries with complex care needs and high costs; promoting community integration through long-term services and supports; and supporting physical and mental health integration. In addition, IAP also works with states through its functional areas, or levers, for Medicaid delivery system reform: data analytics, performance improvement, quality measurement, and value-based payment and financial simulations.[256]

Medical respite: The National Health Care for the Homeless Council describes medical respite care as "acute and post-acute care for persons experiencing homelessness who are too ill or frail to recover from a physical illness or injury on the streets but are not ill enough to be in a hospital." Medical respite care "is offered in a variety of settings including freestanding facilities, homeless shelters, nursing homes, and transitional housing." It "is short-term residential care that allows individuals experiencing homelessness the opportunity to rest in a safe environment while accessing medical care and other supportive services."[257]

Medication-assisted treatment (MAT): SAMHSA describes MAT as "the use of medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of SUDs. Research shows that a combination of medication and therapy can successfully treat these disorders, and for some people struggling with addiction, MAT can help sustain recovery." MAT is primarily used to treat opioid use disorder (OUD) and alcohol use disorder (AUD). Three medications have been approved by the U.S. Food and Drug Administration for each disorder. For OUD, they are methadone, buprenorphine, and naltrexone. For AUD, they are acamprosate, disulfiram, and naltrexone.[258]

Money Follows the Person (MFP) Demonstration: The Money Follows the Person (MFP) Rebalancing Demonstration Grant helps states rebalance their Medicaid long-term care systems. There are currently forty-three states and the District of Columbia participating in the demonstration. MFP program goals include: increase the use of home and community-based

services (HCBS) and reduce the use of institutionally-based services; eliminate barriers in state law, state Medicaid plans, and state budgets that restrict the use of Medicaid funds to let people get long-term care in the settings of their choice; strengthen the ability of Medicaid programs to provide HCBS to people who choose to transition out of institutions; and put procedures in place to provide quality assurance and improvement of HCBS. The authorizing legislation for the demonstration required that the Secretary of the Department of Health and Human Services provide for a national evaluation of the MFP demonstration and submit a final report to the president and Congress that presents the findings and conclusions of this evaluation: https://www.medicaid.gov/medicaid/ltss/downloads/money-follows-the-person/mfp-rtc.pdf .

Motivational Interviewing: The ***former*** SAMHSA-HRSA Center for Integrated Health Solutions defines motivational interviewing as "a clinical approach that helps people with mental health and SUDs and other chronic conditions such as diabetes, cardiovascular conditions, and asthma make positive behavioral changes to support better health. The approach upholds four principles— expressing empathy and avoiding arguing, developing discrepancy, rolling with resistance, and supporting self-efficacy (client's belief s/he can successfully make a change)."[259]

Olmstead: Olmstead refers to the June 1999 United States Supreme Court decision in *Olmstead v. L.C.* which upheld Title II of the Americans with Disabilities Act and the right of individuals with disabilities to live in the least restrictive, most integrated settings possible. The decision requires states to plan affirmatively to serve people in integrated, community-based settings. Since that decision, many states have worked to transition from institutionally-based systems of care (e.g., state hospitals, residential care homes, adult care homes) to more integrated community-based models like supportive housing.[260]

Opioid use disorder (OUD): OUD is defined as a "problematic pattern of opioid use leading to clinically significant impairment or distress."[261]

Oxford housing: Oxford Housing refers to self-supporting and democratically-run substance-free residences that host 6 to 10 recovering individuals per house and require that all members maintain abstinence from drugs and alcohol. Oxford House, Inc., a nonprofit umbrella organization, provides an oversight network connecting Oxford Houses in 43 states and the District of Columbia.[262]

Per-member-per-month (PMPM): "States typically pay managed care organizations for risk-based managed care services through fixed periodic payments for a defined package of benefits. These capitation payments are typically made on a per member per month (PMPM) basis." This is a fixed monthly amount to provide services for an individual member.[263]

Permanent housing: HUD defines permanent housing as "community-based housing without a designated length of stay in which formerly homeless individuals and families live as independently as possible."[264]

Permanent Supportive Housing: HUD defines permanent supportive housing as "permanent housing with indefinite leasing or rental assistance paired with supportive services to assist homeless persons with a disability or families with an adult or child member with a disability achieve housing stability."[265]

Person-centered planning: The U.S. Department of Health & Human Services describes person-centered planning as a process directed by the person with service needs which identifies recovery goals, objectives, and strategies. Person-centered care is aligned with the requirements of section 2402(a) of the Affordable Care Act.[266]

Pre-paid ambulatory health plan: Defined at 42 C.F.R. § 438.2. Prepaid ambulatory health plan means an entity that (1) Provides services to enrollees under contract with the state, and on the basis of capitation payments, or other payment arrangements that do not use state plan payment rates; (2) Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3) Does not have a comprehensive risk contract.[267]

Pre-paid inpatient health plan: Defined at 42 C.F.R. § 438.2. Prepaid inpatient health plan means an entity that (1) Provides services to enrollees under contract with the State, and on the basis of capitation payments, or other payment arrangements that do not use State plan payment rates; (2) Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) Does not have a comprehensive risk contract.[268]

Projects for Assistance in Transition from Homelessness: Projects for Assistance in Transition from Homelessness is a formula grant program that funds services for people with

serious mental illness experiencing homelessness. Administered by SAMHSA, Projects for Assistance in Transition from Homelessness provides funds to all 50 states, the District of Columbia, Puerto Rico, the Northern Mariana Islands, Guam, American Samoa, and the U.S. Virgin Islands. Each state or territory solicits proposals and awards funds to local public or nonprofit organizations known as Projects for Assistance in Transition from Homelessness providers, of which there are approximately 500 across the U.S. Services offered may not be supported by mainstream mental health programs and can include outreach, screening and diagnostic treatment, habilitation and rehabilitation, community mental health, SUD treatment, referrals for primary health care, job training, educational services, and housing, services as specified in section 522(b)(10) of the Public Health Service Act.[269]

Rapid Re-housing: Rapid re-housing is a HUD-funded "intervention, informed by a Housing First approach that is a critical part of a community's effective homeless crisis response system. [Rapid re-housing] rapidly connects families and individuals experiencing homelessness to permanent housing through a tailored package of assistance that may include the use of time-limited financial assistance and targeted supportive services."[270]

Recovery: Recovery is defined by SAMHSA as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." The guiding principles of recovery are hope; person-driven; many pathways; holistic; peer support; relational; culture; addresses trauma; strengths/responsibility; and respect.[271]

Recovery housing: SAMHSA defines recovery housing as "safe, healthy, family-like substance-free living environments that support individuals in recovery from addiction. While recovery residences vary widely in structure, all are centered on peer support and a connection to services that promote long-term recovery. Recovery housing benefits individuals in recovery by reinforcing a substance-free lifestyle and providing direct connections to other peers in recovery, mutual support groups and recovery support services. Substance-free does not prohibit prescribed medications taken as directed by a licensed prescriber, such as pharmacotherapies specifically approved by the Food and Drug Administration (FDA) for treatment of opioid use disorder as well as other medications with FDA-approved indications for the treatment of co-occurring disorders."[272,273]

Substance Abuse and Mental Health Services Administration **(SAMHSA's) Performance Accountability and Reporting System (SPARS):** SPARS is an "online data entry, reporting, technical assistance request, and training system to support grantees in reporting timely and accurate data to SAMHSA."[274]

Section 330(h) Homeless Population: For the purposes of health centers receiving a Health Center Program award or designation under section 330(h) of the Public Health Service Act, the population served includes individuals experiencing homelessness. A "homeless individual" is defined by the Act as "an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations and an individual in transitional housing." Under section 330(h), a health center may continue to provide services for up to 12 months to formerly homeless individuals whom the health center has previously served but are no longer homeless as a result of becoming a resident in permanent housing and may also serve children and youth at risk of homelessness, homeless veterans, and veterans at risk of homelessness.[275]

Shelter: HUD defines emergency shelter, at 24 CFR § 91.5, as "any facility, the primary purpose of which is to provide a temporary shelter for the homeless in general or for specific populations of the homeless and which does not require occupants to sign leases or occupancy agreements."[276]

Sober (or Clean and Sober) housing: HUD equates "sober-living environments" with "Recovery Housing."[277]

Social Determinants of Health: Social determinants of health (SDOH) are conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes. SDOH, sometimes referred to as unmet social needs, may include access to nutritional food, affordable and accessible housing, convenient and efficient transportation, safe neighborhoods, strong social connections, quality education, and opportunities for meaningful employment. See https://www.cdc.gov/socialdeterminants/index.htm for more information on SDOH. Additionally, work is under way through the Office of the National Coordinator of Health Information Technology that is focused on housing terminology via Project Gravity: See

https://confluence.hl7.org/display/GRAV/The+Gravity+Project, which is a stakeholder-led, collaborative, grass-roots terminology development process aligned with HL7 / FHIR.

State Innovation Model: The CMS "[State Innovation Models] … initiative partners with states to advance multi-payer health care payment and delivery system reform models. Each state-led model aims to achieve better quality of care, lower costs, and improved health for the population of the participating states or territory. The initiative is testing the ability of state governments to utilize policy and regulatory levers to accelerate health system transformation to meet these aims."[278]

State Opioid Response: SAMHSA provided State Opioid Response Grants to states and territories to address the opioid crisis by increasing access to MAT using the three FDA-approved medications for the treatment of OUD, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment and recovery activities for OUD.[279]

State Targeted Response to the Opioid Crisis: SAMHSA provided State Targeted Response to the Opioid Crisis Grants to single state agencies in order "to address the opioid crisis by increasing access to treatment, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment and recovery activities for [OUD]."[280]

State-wideness: The Social Security Act requires at § 1902(a)(1), 42 USC § 1396a, that a state Medicaid program cannot exclude enrollees or providers because of where they live or work in the state. A waiver of "state-wideness" can limit the geographic area in which a state is testing a new program or facilitate a phased-in implementation of a program.[281]

Substance use disorder (SUD): SUDs "occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home."[282]

Supported employment: CMS defines supported employment as "the ongoing supports to participants who, because of their disabilities, need intensive on-going support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce at or above the state's minimum wage, at or

above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities". The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals."[283]

Supportive housing: The U.S. Interagency Council on Homelessness describes supportive housing as a model that combines non-time-limited affordable housing assistance with wrap-around supportive services for people experiencing homelessness and people with disabilities. The model has been shown to resolve homelessness, increase housing stability, improve health and lower public costs by reducing the use of publicly-funded crisis services such as shelters, hospitals, psychiatric centers, jails, and prisons.[284] Please note that "supportive housing" and "permanent supportive housing" are often used interchangeably.

Transitional housing: HUD-funded transitional housing provides people experiencing homelessness a place to stay combined with supportive services for up to 24 months.[285]

Trauma-Informed Care: SAMHSA describes trauma-informed care as a strengths-based service delivery approach "that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment."[286] It also involves vigilance in anticipating and avoiding institutional processes and individual practices that are likely to re-traumatize individuals who already have histories of trauma, and it upholds the importance of consumer participation in the development, delivery, and evaluation of services.[287]

Trauma-specific treatment services: SAMHSA describes these services as evidence-based and promising practices that facilitate recovery from trauma. The term "trauma-specific services" refers to prevention, intervention, or treatment services that address traumatic stress as well as any co-occurring disorders (including substance use and mental disorders) that developed during or after trauma.[288]

Value-based purchasing: Value-based purchasing links "provider payments to improved performance by health care providers. This form of payment holds health care providers

accountable for both the cost and quality of care they provide. It attempts to reduce inappropriate care and to identify and reward the best-performing providers."[289]

Vulnerability index – Service Prioritization Decision Assistance Tool (VI-SPDAT)©: The VI-SPDAT is one of several assessment tools commonly used by many communities to screen and prioritize individuals experiencing homelessness for assistance. It combines the Vulnerability Index (VI) which screens for medical risk factors with the Service Prioritization Decision Assistance Tool (SPDAT) which screens for social risk factors.[290]

Endnotes

[1] There are multiple definitions of homelessness, including definitions that vary between federal agencies. See Appendix D for the definition of a *homeless individual* that the U.S. Department of Health and Human Services (HHS) uses under the Public Health Services Act (42 U.S. Code § 254b(h)(5)(A)) and for the definitions of *homeless* and at *risk of homelessness* that HUD uses under the Homeless Emergency Assistance and Rapid Transition to Housing Act of 2009 (24 Code of Federal Regulations [CFR] § 91.5 (2019)). HUD issued a final rule on December 4, 2015, on the definition of *chronically homeless*, "Homeless Emergency Assistance and Rapid Transition to Housing: Defining 'Chronically Homeless.'" 24 CFR Parts 91 and 578. Available at https://www.govinfo.gov/content/pkg/FR-2015-12-04/pdf/2015-30473.pdf. Accessed on June 20, 2019.

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Track 1: Supporting Housing Tenancy: This track, which ran from February 2016 through April 2016, focused on providing states with innovative strategies that are being used or could be used by states to support housing tenancy services for community-based long-term services and supports to Medicaid beneficiaries. Thirty-one state Medicaid agencies were invited to participate in this webinar series.

Track 2: State Medicaid-Housing Agency Partnerships: The goals of the State Medicaid-Housing Agency Partnerships Track are to (1) develop public and private partnerships between the Medicaid and housing systems and (2) support states in the creation of detailed action plans that foster additional community living opportunities for Medicaid beneficiaries. IAP is working closely with its federal partners—HUD, the Substance Abuse and Mental Health Services Administration, the Office of the Assistant Secretary for Planning and Evaluation, and the U.S. Interagency Council on Homelessness—on planning and coordination of this program support. IAP leverages its collaboration with federal agencies to promote partnerships between state Medicaid agencies, state housing finance agencies, public housing agencies, state and local service agencies, and providers.

- Starting in April 2016, selected states—California, Connecticut, Hawaii, Illinois, Kentucky, New Jersey, Nevada, and Oregon—participated in the track for a 6-month period.

- Starting in August 2017, selected states—Alaska, Massachusetts, Michigan, Minnesota, Nebraska, Texas, Utah, and Virginia—participated in the track for a 9-month period.
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