DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMCS Informational Bulletin

DATE: May 10, 2024

FROM: Daniel Tsai
Deputy Administrator and Director
Center for Medicaid and CHIP Services

SUBJECT: Opportunities for Improving Access to Mental Health and Substance Use Disorder Services for Medicaid and CHIP Enrollees Experiencing Homelessness

The Center for Medicaid and CHIP Services (CMCS) is issuing this CMCS Informational Bulletin (CIB) to encourage states to consider leveraging available Medicaid and Children's Health Insurance Program (CHIP) opportunities to improve access to mental health (MH) and substance use disorder (SUD) services for individuals experiencing homelessness.

Background

As one of the largest sources of funding for MH and SUD treatment,[1] Medicaid offers significant opportunities to improve access to MH and SUD treatment and recovery support. Many individuals at risk for or experiencing homelessness are eligible for Medicaid,[2] and can benefit from Medicaid's health care coverage, that includes a full array of treatment and services for mental illness and SUDs. Medicaid's comprehensive benefit package is especially critical for enrollees with mental illness and/or SUDs who are experiencing homelessness. In 2023, 21 percent of persons experiencing homelessness reported having a serious mental illness (SMI) and over 16 percent reported having a chronic SUD.[3] Numerous studies have illustrated the bi-directional relationship between mental illness and homelessness, highlighting that mental illness does not cause homelessness and homelessness itself can trigger or exacerbate mental and emotional distress.[4]

In general, Medicaid and CHIP enrollees have higher rates of mental illness and SUDs than privately insured and uninsured individuals.[5] Most enrollees with mental illness or SUDs qualify for Medicaid because of their low incomes,[6,7] and many individuals qualify for Medicaid based on a disability, including SMI.[8] Furthermore, research has shown that poverty in childhood and among adults can cause poor mental health, and mental health problems can lead to lower income through loss of employment, underemployment, and fragmentation of social relationships.[9]

In light of increased numbers of persons experiencing homelessness,[10] CMCS encourages state Medicaid and CHIP agencies to expand their efforts to increase access to MH and SUD treatment and support services among Medicaid- and CHIP-eligible individuals and families at risk for or experiencing homelessness. Furthermore, CMCS continues to prioritize initiatives that take a whole-person approach to addressing the needs of individuals experiencing homelessness, such as providing additional services and treatment on a voluntary basis and partnering with homeless services and housing organizations to support access to long-term housing. Studies show that interventions providing permanent supportive housing to individuals with SUD experiencing homelessness are associated with decreased emergency room visits and hospitalizations.[11, 12] Moreover, research indicates that programs helping people experiencing chronic homelessness and SUD to access stable housing, including Housing First programs that do not require abstinence, result in reduced substance use and reduced incarceration as well as less use of hospital and emergency services and other Medicaid-funded services and can lead to lower overall costs.[13] In addition, research studies have found that supportive housing programs result in improved housing stability and community functioning among individuals with SMI.[14]

It is also important to note that certain groups of individuals, including some underserved racial and ethnic groups, are at higher risk of housing instability and also face greater challenges to accessing MH and SUD treatment; for example, Black and Hispanic Medicaid enrollees with depression are less likely to receive treatment compared to White beneficiaries, and Black adults with opioid use disorder are less likely to receive medication for opioid use disorder (MOUD) than White adults.[15] In addition, rates of suicide and overdose deaths have been rising faster among individuals in these groups than the general population indicating a growing need for improved access to MH and SUD treatment.[16] Moreover, underserved racial and ethnic populations are more affected by housing insecurity,[17] and as noted previously, homelessness has a harmful effect on mental health.[18] Medicaid and CHIP offer opportunities to assist those with housing insecurity and address elevated barriers to MH and SUD treatment among underserved racial and ethnic groups as these groups comprise a majority of Medicaid enrollees.[19]

To assist states in considering additional ways to increase access to MH and SUD treatment, improve support services among Medicaid- and CHIP-eligible people experiencing homelessness, and also advance health equity, this CIB highlights some of the more recent opportunities in Medicaid and CHIP for enhancing access to MH and SUD treatment and services for enrollees. In addition, references to some previously posted guidance documents and other resources describing additional Medicaid and CHIP authorities supporting coverage of MH and SUD treatment and recovery support are included at the end of this document.

Certified Community Behavioral Health Clinic Demonstration

The Certified Community Behavioral Health Clinic (CCBHC) demonstration[20] promotes expansion of comprehensive services and supports in ambulatory clinic settings for Medicaid-enrolled individuals with mental illnesses and/or SUDs, including persons at risk for or experiencing homelessness. This demonstration supports clinics to provide a full array of mental health and SUD treatment services as well as case management and additional support services for anyone seeking help regardless of where they live. These programs can be particularly helpful for individuals who do not have stable housing. Moreover, CCBHCs primarily serve

individuals with more serious MH conditions and/or SUDs, and as noted above, individuals with these conditions are more likely to experience or be at higher risk for experiencing homelessness.

CMS and the Substance Abuse and Mental Health Services Administration (SAMHSA) jointly administer the CCBHC demonstration, with states receiving enhanced federal Medicaid match[21] for services provided to enrollees by community-based clinics that meet certain criteria.[22] Eight states[23] currently participate in the demonstration program.

The CCBHC Certification Criteria require that these clinics provide access to comprehensive MH and SUD services, and "CCBHCs must provide services to anyone seeking help for a mental health or substance use condition, regardless of their place of residence, ability to pay, or age."[24] In addition, CCBHCs must provide care coordination to help people navigate MH and SUD care, physical health care, as well as social services (including housing services, educational systems, and employment opportunities), as needed. Moreover, CCBHCs provide care in community settings and can provide services in homes, public housing, shelters, and as part of supportive housing programs.

In general, CCBHCs must provide the following nine categories of services, either directly or through formal relationships with designated collaborating organizations:

1. Crisis Services,
2. Screening, Assessment, Diagnosis & Risk Assessment,
3. Person- and Family-Centered Treatment Planning,
4. Outpatient Mental Health & Substance Use Services,
5. Outpatient Primary Care Screening and Monitoring,
6. Targeted Case Management,[25]
7. Psychiatric Rehabilitation Services,
8. Peer Support, Family Support & Counselor Services, and
9. Intensive, Community-Based Mental Health Care for Members of the Armed Forces and Veterans.

The CCBHC certification criteria include a number of requirements that explicitly call for actions to improve access to MH and SUD services for persons experiencing homelessness; for example, CCBHCs are required to ----

- Conduct "outreach, engagement, and retention activities to support inclusion and access for underserved individuals and populations" (Criteria 2.a.6),
- Ensure "no individual is denied behavioral health care services, including but not limited to crisis management services, because of place of residence, homelessness, or lack of a permanent address" (Criteria 2.e.1),
- Provide targeted case management to "assist people receiving services in sustaining recovery and gaining access to needed medical, social, legal, educational, housing, vocational, and other services and supports," and
- Provide psychiatric rehabilitation services that include supporting people receiving services to "find and maintain safe and stable housing" (Criteria 4.i.1).

In addition, the certification criteria encourage CCBHCs to "consider developing [service delivery] protocols for populations that may transition frequently in and out of the services area such as children who experience out-of-home placements and adults who are displaced by incarceration or housing instability" (Criteria 2.e.2). Furthermore, the criteria recommend that CCBHCs provide targeted case management particularly during "critical periods, such as episodes of homelessness or transitions to the community from jails or prisons" (Criteria 4.h.1).

Availability of CCBHCs will increase significantly in the future since the demonstration program was extended and expanded by Section 11001 of the 2022 Bipartisan Safer Communities Act (Pub. L. 117-159). Beginning July 1, 2024, and every two years after, up to ten additional states may be selected to participate in the demonstration. In March 2023, planning grants were awarded to 15 states[26] to help them prepare to apply for participation in the demonstration. CMCS and SAMHSA are working closely together to add up to ten additional states to the program in summer of 2024, followed by additional planning grants and selection of additional states for participation every two years thereafter.

In addition, the Consolidated Appropriations Act of 2024, enacted March 9, 2024, includes a provision that creates a new Medicaid state plan option for states to add coverage of services provided by clinics that those states certify as meeting the CCBHC demonstration criteria.[27] This provision went into effect upon enactment. It does not provide enhanced federal match for CCBHC services or dictate how states must reimburse CCBHCs as in the CCBHC demonstration. Nonetheless, it creates an additional option for states to incorporate the CCBHC care delivery model into their Medicaid programs and further supports expansion of these programs that offer comprehensive services that are particularly well suited for individuals with more serious MH conditions or SUDs including individuals experiencing or at risk for homelessness.

Section 1115 Demonstrations for Improving Community Reentry Following Incarceration

Another way for state Medicaid agencies to improve access to MH and SUD treatment among individuals experiencing homelessness or at risk for homelessness is through section 1115 demonstrations focused on improving transitions out of incarceration. As outlined in a 2023 SMD letter entitled "Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated" (SMDL #23 -003), this demonstration opportunity provides states with federal financial participation for expenditures for certain pre-release health care services provided to individuals who are incarcerated and otherwise eligible for Medicaid prior to their release, including those likely to experience homelessness.[28]

In general, Medicaid funds may not be used to pay for services for individuals while they are incarcerated, except when they are inpatients in a medical institution.[29] Through this new section 1115 reentry demonstration, states may qualify for federal match for care provided to enrollees as they are transitioning out of incarceration thus improving access to MH and SUD treatment. States have flexibility to define this pre-release period as 30 days or more and up to 90 days

immediately prior to the expected release date. In addition, this demonstration opportunity will help individuals leaving jails and prisons address barriers to obtaining housing and other social supports as they reenter their communities.

States must, at a minimum, provide coverage for the following benefits during the pre-release period:

- Case management to assess and address physical and behavioral health needs and health-related social needs (HRSN);
- Medications for opioid use disorder (MOUD) for all types of SUDs, as clinically appropriate, with accompanying counseling; and
- 30-day supply at least of all prescription medications that have been prescribed for the beneficiary at the time of release, provided to the beneficiary immediately upon release from the correctional facility.

As specified in the SMD letter, pre-release case management services must include connecting individuals to post-release services covered by Medicaid, such as help setting up appointments with and providing warm hand-offs to community providers. In addition, as part of these section 1115 demonstrations, case managers are expected to develop person-centered care plans including screening for suicide risk, screening for overdose risk, peer support services, and linkages to housing, making connections to housing providers, if necessary. Case managers are also expected to follow up with individuals post-release to ensure they are able to access the MH, SUD, and housing services they need.

As highlighted in the list of required pre-release benefits and the descriptions of these benefits, the reentry section 1115 demonstration initiative offers a key opportunity for states to improve access to MH and SUD treatment among a population at significant risk of experiencing homelessness. As of February of 2024, CMS has approved two states' proposals for these demonstrations, California[30] and Washington,[31] and 16 additional state applications are under consideration.

Addressing Health-Related Social Needs

CMS supports states in addressing HRSN which, when unmet, can drive lapses in coverage and access to care, higher downstream medical costs, worse health outcomes, and perpetuation of health inequities including among enrollees with mental illness and/or SUDs.[32] By addressing HRSN, state Medicaid and CHIP programs can help their enrollees stay connected to coverage and access needed health care services, and supplement – but not supplant – existing local, state, and federal supports. Under specific Medicaid and CHIP authorities, there are different evidence-based ways that state programs can partner with housing and social service agencies to improve access for individuals with specific clinical conditions including mental illness and SUDs. Housing services and supports are linked to improved health outcomes for individuals with MH conditions and SUDs who are experiencing homelessness and are examples of interventions that address HRSN.

In November 2023, CMS published guidance on opportunities to cover clinically appropriate and evidence-based services and supports that address HRSN (HRSN Guidance), and a framework of services and supports (HRSN Framework) that CMS considers allowable under specific Medicaid and CHIP authorities and under 1115 demonstrations.[33] The HRSN Guidance and HRSN Framework issued by CMS describe opportunities for states, in partnership with housing and social services, to provide clinically appropriate services such as housing transition services and case management that do not supplant existing social services and housing assistance, comply with federal laws and statutory authorities, and adhere to program goals.

As of March 2024, CMS has approved eight section 1115 demonstrations under the HRSN Framework. States propose populations of focus, such as individuals experiencing homelessness. In order to receive HSRN services, individuals must meet state-determined clinical and needs-based criteria, subject to CMS approval. States must also meet additional conditions for CMS approval, including budget neutrality expenditure caps and requirements to ensure provider payment rates in primary care, obstetrical care, and MH and SUD care meet minimum thresholds, and, if not, state must make a commitment to improve those payment rates. Connections to care can only be successful if individuals, such as those with MH conditions and SUDs, have timely access to providers.

In addition to section 1115 demonstrations, states can provide services related to HRSNs through other Medicaid authorities such as section 1915 home- and community-based services (HCBS) authorities[34] and managed care "in-lieu-of" services and settings (ILOSs),[35] as well as CHIP Health Services Initiatives.[36] For example, CMS has approved several state plan amendments covering housing-related support services for individuals experiencing homelessness who meet HCBS needs-based eligibility criteria through the section 1915(i) authority. On January 4, 2023, CMS published guidance that describes innovative options states may consider employing in Medicaid managed care programs to address HRSN through the use of a service or setting that is provided to an enrollee in lieu of another service or setting (known as an "in lieu of" service or ILOS).[37] There are additional opportunities to support individuals with case management services through other authorities, and section 1945 Health Homes can be an effective mechanism to coordinate care for people with Medicaid who have chronic conditions.

CMS remains committed to partnering with states to effectively use these available opportunities to address HRSN. For instance, in November 2023, the U.S. Department of Health & Human Services (HHS) and the U.S. Department of Housing and Urban Development (HUD) announced the launch of a new opportunity to support states with the implementation of innovative state strategies to provide housing-related supports and services and care coordination services under Medicaid authorities to individuals who are experiencing homelessness or at risk of experiencing homelessness called the Housing and Services Partnership Accelerator. In February 2024, HHS and HUD announced that eight states and the District of Columbia had been selected to participate in this Accelerator. HHS and HUD will provide them with resources such as intensive federal technical assistance and opportunities for state peer-to-peer learning.

Section 1115 Demonstrations Focusing on Improving Treatment for Substance Use Disorders

CMS also partners with states on demonstration projects to improve access to the full continuum of care for SUD treatment, including in short-term residential treatment and inpatient settings, through a section 1115 demonstration opportunity outlined in a 2017 SMD letter entitled "Strategies to Address the Opioid Epidemic"[38] (SMDL #17-003).

For this SUD-focused demonstration initiative (as a condition of demonstration approval), states are required to carry out a number of actions to improve access to, and quality of, care as embodied in the following milestones specified in the 2017 SMD letter:

- Access to critical levels of care for opioid use disorder (OUD) and other SUDs,
- Widespread use of evidence-based, SUD-specific patient placement criteria,
- Use of nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications, including implementation of a requirement that residential treatment facilities offer medication-assisted treatment (MAT)on-site or facilitate access off-site,
- Sufficient provider capacity at each level of care,
- Implementation of comprehensive treatment and prevention strategies to address opioid misuse and OUD, and
- Improved care coordination and transitions between levels of care.

As part of these demonstrations, states have reported adding or expanding coverage for a range of SUD services, including services focused on enrollees experiencing homelessness via supportive housing programs. From February 2020 through July 2021, ten percent of states implementing these demonstrations added supportive housing services for individuals with SUD.[39] States have, for example, established new Medicaid benefits for services to help enrollees remain in stable housing including case management services. States have also expanded existing Medicaid coverage of supportive housing benefits to include coverage of individuals with SUDs who receive services though behavioral health services organizations. Research has indicated that supportive housing programs providing access to stable housing with supportive services can help individuals with SUDs who are experiencing homelessness reduce substance use, utilization of emergency services as well as incarceration.[40]

Section 1115 Demonstrations Focusing on Improving Care for Individuals with Serious Mental Illness

Another demonstration opportunity with the goal of improving the availability of treatment services and supports for Medicaid enrollees with serious MH conditions who are experiencing homelessness is available through a section 1115 demonstration initiative announced in a 2018 State Medicaid Director (SMD) letter entitled "Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness (SMI) or Children with a Serious Emotional Disturbance (SED)" (#18-011). Through this initiative, CMS supports state section 1115 demonstrations aimed at improving access to a full continuum of care including outpatient

services, intensive outpatient programs, and short-term (30 days state-wide average, 60 days maximum per individual) services in specialized inpatient and residential treatment settings that are ordinarily excluded from Medicaid payment, , In addition to filling gaps in the care continuum, states are required, as part of these demonstrations, to implement a range of strategies for improving access to, engagement in, and quality of care for individuals with SMI or SED. The letter also describes evidence-based interventions and policies states can implement.[41]

States participating in these demonstrations are required to submit a SMI/SED demonstration plan that describes how the state will meet the following four milestones:

1. Ensure quality of care in psychiatric hospitals and residential settings,
2. Improve care coordination and transitions to community-based care,
3. Increase access to a continuum of care including crisis stabilization services, and
4. Support earlier identification and engagement in treatment including through increased integration.

In addition, the 2018 SMD letter describes specific actions that states are expected to take to achieve each of these milestones. These actions include an annual assessment of availability of mental health services at all levels of care throughout the state, commitment to a financing plan aimed at increasing availability of community-based services, implementation of strategies for engaging individuals with serious MH conditions in treatment sooner including through greater availability of supported employment and supported education programs, increased integration of MH and SUD services in non-specialty settings including primary care clinics, and establishment of additional settings focused on providing specialized MH and SUD services for children and adolescents. Importantly, as part of addressing the second milestone above, states must require participating psychiatric hospitals and residential treatment facilities to implement processes for assessing the housing situations of individuals transitioning to the community and connecting those who are homeless or have unsuitable or unstable housing with community providers that coordinate housing services.

At least ten states[42] with these demonstrations have completed or are developing new rules and policies to ensure psychiatric hospitals and residential treatment settings assess beneficiaries' housing situations and support transition to stable housing. In addition, states are implementing strategies to integrate supportive housing services into treatment. This includes making administrative policy changes that require providers and/or Medicaid managed care plans to assess housing needs during discharge from a psychiatric hospital or residential treatment facility, by providing funding, training, and resources for case management programs that help connect enrollees to housing supports, and by using existing Medicaid benefits and/or waivers to provide supportive services to beneficiaries with SMI. Other strategies include updating the state Medicaid provider manual to explicitly require hospitals to assess housing needs. Other state actions have been to change hospital licensing rules to ensure that psychiatric hospitals assess their beneficiaries' housing needs and revise state administrative codes to require hospitals to provide discharge planning that includes addressing housing supports. In addition, states have provided funding to community mental health centers (through programs to prevent incarceration among individuals with SMI) to provide case management for individuals with SMI that includes

linking them to housing support. Other opportunities states have used include accessing the 1915(i) supportive housing state plan benefit to provide transitional and/or sustained supportive housing services to eligible individuals who are experiencing homelessness or at-risk of experiencing homelessness.[43] All of these activities are examples of how states can use Medicaid authorities to support improved access among enrollees with SMI experiencing homelessness to stable housing that is associated with improved health outcomes and lower overall costs of care.[44]

Additional Resources

CMCS has issued numerous guidance documents describing opportunities for improving access to MH and SUD treatment and recovery supports through Medicaid and CHIP. Below is a list of some of those resources that states should consider for improving access to treatment and support for people with these conditions who are experiencing or at risk for homelessness.

- Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services
  https://www.medicaid.gov/federal-policy-guidance/downloads/sho21008.pdf

- Coverage of Early Intervention Services for First Episode Psychosis
  https://www.medicaid.gov/federal-policy-guidance/downloads/cib-10-16-2015.pdf

- Coverage of Peer Support Services
  https://www.medicaid.gov/federal-policy-guidance/downloads/SMD081507A.pdf

- Coverage of Housing-Related Activities and Services for Individuals with Disabilities
  https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/CIB-06-26-2015.pdf

- Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH)
  https://www.medicaid.gov/sites/default/files/2022-01/sho21001_0.pdf

- Mandatory Medicaid State Plan Coverage of Medication-Assisted Treatment
  https://www.medicaid.gov/federal-policy-guidance/downloads/sho20005.pdf

- Coverage and Payment of Interprofessional Consultation in Medicaid and CHIP
  https://www.medicaid.gov/federal-policy-guidance/downloads/sho23001.pdf

- Opportunities to Design Innovative Services Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance (first half of this SMD letter describing best practices and evidence-based models along with relevant Medicaid state plan and other Medicaid and CHIP authorities other than section 1115 authorities)
  https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf

- CMS and SAMHSA Joint Guidance on Services for Children, Youth and Young Adults with Significant Mental Health Conditions

https://www.medicaid.gov/federal-policy-guidance/downloads/cib-05-07-2013.pdf

- CMS and SAMHSA Joint Guidance on Coverage of Services for Youth with SUD https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-01-26-2015.pdf

- Medicaid and CHIP Telehealth Toolkit https://www.medicaid.gov/medicaid/benefits/telehealth/medicaid-chip-telehealth-toolkit/index.html

- CMCS MH and SUD Action Plan https://www.medicaid.gov/medicaid/benefits/downloads/cmcs-mntl-helth-substnce-disrdr-actn-plan.pdf

Conclusion

CMS encourages State Medicaid and CHIP agencies to consider the options outlined above as pathways to improving access to MH and SUD treatment and support services for Medicaid and CHIP enrollees experiencing or at risk for homelessness. For additional information, please contact Kirsten Beronio, Senior Advisor on Mental Health and Substance Use Disorder Issues, at kirsten.beronio1@cms.hhs.gov.

---

[1] Agency for Healthcare Research and Quality. Healthcare Expenditures for Treatment of Mental Disorders: Estimates for Adults Ages 18 and Older, U.S. Civilian Noninstitutionalized Population, 2019. Statistical Brief #539. Feb. 2022. https://meps.ahrq.gov/data_files/publications/st539/stat539.pdf; Davis, K. *Expenditures for Treatment of Mental Health Disorders among Children, Ages 5–17, 2009–2011: Estimates for the U.S. Civilian Noninstitutionalized Population*. Statistical Brief #440. June 2014. Agency for Healthcare Research and Quality, Rockville, MD http://www.meps.ahrq.gov/mepsweb/data_files/publications/st440/stat440.shtml .

[2] See, e.g., Kushel M, Moore T, et al. Toward a New Understanding: The California Statewide Study of People Experiencing Homelessness. UCSF Benioff Homelessness and Housing Initiative. June 2023. https://homelessness.ucsf.edu/sites/default/files/2023-06/CASPEH_Report_62023.pdf.

[3] Department of Housing and Urban Development. 2023 Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations Report. https://files.hudexchange.info/reports/published/CoC_PopSub_NatlTerrDC_2023.pdf.

[4] Padgett DK. Homelessness, housing instability and mental health: making the connections. BJPsych Bull. 2020 Oct;44(5):197-201. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7525583/.

[5] Kaiser Family Foundation. Demographics and Health Insurance Coverage of Nonelderly Adults with Mental Illness and Substance Use Disorders in 2020. June 6, 2022. https://www.kff.org/mental-health/issue-brief/demographics-and-health-insurance-coverage-of-nonelderly-adults-with-mental-illness-and-substance-use-disorders-in-2020/; Bitsko RH, Claussen AH, Lichstein J, et al. Mental Health Surveillance Among Children — United States, 2013–2019. MMWR Suppl 2022;71(Suppl-2):1–42. https://www.cdc.gov/mmwr/volumes/71/su/su7102a1.htm.

[6] Zur J, Musumeci M, Garfield R. Medicaid's Role in Financing Behavioral Health Services for Low-Income Individuals Kaiser Family Foundation Issue Brief. June 29, 2017. https://www.kff.org/medicaid/issue-brief/medicaids-role-in-financing-behavioral-health-services-for-low-income-individuals/; Guth M, Saunders H, Corallo B, et al. Medicaid Coverage of Behavioral Health Services in 2022: Finding from a Survey of State

Medicaid Programs. Kaiser Family Foundation. Mar 17, 2023. https://www.kff.org/mental-health/issue-brief/medicaid-coverage-of-behavioral-health-services-in-2022-findings-from-a-survey-of-state-medicaid-programs

[7] Kaiser Family Foundation Issue Brief. Ten Things to Know About Medicaid's Role for Children with Behavioral Health Needs. June 19, 2017. https://www.kff.org/medicaid/fact-sheet/ten-things-to-know-about-medicaids-role-for-children-with-behavioral-health-needs/#:~:text=Medicaid%20plays%20an%20important%20role,low%20and%20middle%20income%20families.

[8] Medicaid and CHIP Payment and Access Commission. June 2021 Report to Congress, Chapter 2: Access to Mental Health Services for Adults Covered by Medicaid. https://www.macpac.gov/wp-content/uploads/2021/06/Chapter-2-Access-to-Mental-Health-Services-for-Adults-Covered-by-Medicaid.pdf

[9] Knifton L, Inglis G. Poverty and mental health: policy, practice and research implications. BJPsych Bull. Oct;44(5):193-196 (2020). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7525587/#ref2

[10] U.S. Department of Housing and Urban Development. The 2023 Annual Homelessness Assessment Report to Congress. Dec. 2023. https://www.huduser.gov/portal/sites/default/files/pdf/2023-AHAR-Part-1.pdf.

[11] Tsai, J. Is the Housing First Model Effective? Different Evidence for Different Outcomes. American Journal of Public Health. 110(9), 1376–1377 (2020). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7427255/pdf/AJPH.2020.305835.pdf.

[12] National Academies of Sciences, Engineering, and Medicine. *Permanent Supportive Housing: Evaluating the Evidence For Improving Health Outcomes Among People Experiencing Chronic Homelessness*. The National Academies Press. 2018.

[13] Larimer ME, Malone DK, Garner MD, et al. Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problems. JAMA, 301(13):1349-1357 (2009). https://jamanetwork.com/journals/jama/fullarticle/183666.

[14] Killaspy H, Harvey C, Brasier C, et al. Community-based social interventions for people with severe mental illness: a systematic review and narrative synthesis of recent evidence. World Psych, 21(1): 96-123 (Feb 2022). https://onlinelibrary.wiley.com/doi/10.1002/wps.20940

[15] Donohue JM, Cole ES, James CV, et al. The US Medicaid Program: Coverage, Financing, Reforms, and Implications for Health Equity. JAMA, 328(11):1085–1099 (2022). https://jamanetwork.com/journals/jama/fullarticle/2796374.

[16] Panchal N, Saunders H, Ndugga N. Kaiser Family Foundation Brief: Five Key Findings on Mental Health and Substance Use Disorders by Race/Ethnicity. Sept. 2022. https://www.kff.org/racial-equity-and-health-policy/issue-brief/five-key-findings-on-mental-health-and-substance-use-disorders-by-race-ethnicity/.

[17] Njai R, Siegel P, Yin S, Liao Y. Prevalence of Perceived Food and Housing Security - 15 States, 2013. MMWR Morb Mortal Wkly Rep. Jan 13;66(1):12-15 (2017). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5687269/.

[18] Padgett DK. Homelessness, housing instability and mental health: making the connections. BJPsych Bull. Oct;44(5):197-201 (2020). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7525583/.

[19] See CMS Data Brief on Race and Ethnicity of the national Medicaid and CHIP population in 2020 https://www.medicaid.gov/sites/default/files/2023-08/2020-race-etncity-data-brf.pdf; Donohue JM, Cole ES, James CV, et al. The US Medicaid Program: Coverage, Financing, Reforms, and Implications for Health Equity. JAMA, 328(11):1085–1099 (2022). https://jamanetwork.com/journals/jama/fullarticle/2796374.

[20] The Certified Community Behavioral Health Clinic demonstration was authorized in Sec. 223 of the Protecting Access to Medicare Act of 2014 (P.L. 113-93).

[21] See CMS policies on CCBHC prospective payment system options at https://www.medicaid.gov/medicaid/financial-management/section-223-demonstration-program-improve-community-mental-health-services/index.html.

[22] Substance Abuse and Mental Health Services Administration. Certification Criteria for Certified Community Behavioral Health Clinics. 2023 Update. https://www.samhsa.gov/sites/default/files/ccbhc-criteria-2023.pdf.

[23] States currently participating in the joint CMS-SAMHSA CCBHC demonstration are Minnesota, Missouri, New Jersey, New York, Oklahoma, Oregon, Michigan, and Kentucky.

[24] Substance Abuse and Mental Health Services Administration. Certified Community Behavioral Health Center (CCBHC) Certification Criteria. Published February 2023. Certified Community Behavioral Health Clinics (CCBHCs) | SAMHSA.

[25] According to the certification criteria established for clinics participating in the CCBHC demonstration, "CCBHC targeted case management services are separate from and do not follow state targeted case management rules under the Medicaid state plan or waivers." See p. 36 of the criteria at https://www.samhsa.gov/sites/default/files/ccbhc-criteria-2023.pdf.

[26] States that received CCBHC planning grants in March 2023 are Alabama, Delaware, Georgia, Iowa, Kansas, Maine, Mississippi, Montana, North Carolina, New Hampshire, New Mexico, Ohio, Rhode Island, Vermont, and West Virginia.

[27] Section 209, Subtitle A- Public Health Extenders, Title I-Health and Human Services, Subdivision G Consolidated Appropriations Act of 2024 (Pub. L. 118-42). https://legiscan.com/US/text/HB4366/2023.

[28] Center for Medicaid and CHIP Services, "Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals who are Incarcerated" (SMD#23-003), April 17, 2023. https://www.medicaid.gov/sites/default/files/2023-12/smd23003.pdf.

[29] See Social Security Act, Section 1905(a).

[30] Tsai, D (January 26, 2023). Letter from CMS to California State Medicaid Director Approving Medicaid Demonstration Project "CalAIM Demonstration" through December 31, 2026. https://www.medicaid.gov/sites/default/files/2023-01/ca-calaim-ca1.pdf.

[31] Tsai, D (June 23, 2023). Letter from CMS to Washington State Medicaid Director Approving Medicaid Demonstration Project Washington State Medicaid Transformation Project 2.0 through June 30th 2028. https://www.medicaid.gov/sites/default/files/2023-06/wa-medicaid-transformation-ca-06302023.pdf.

[32] An individual's HRSN are derived from a person-specific assessment of social determinants of health. While SDOH are broad environmental conditions, HRSN are specific to an individual and when unmet, these individual-level adverse social conditions contribute to poor health outcomes.

[33] Center for Medicaid and CHIP Services, "Coverage of Health-Related Social Needs (HRSN) Services in Medicaid and the Children's Health Insurance Program (CHIP)", Nov. 2023. https://www.medicaid.gov/sites/default/files/2023-11/hrsn-coverage-table.pdf.

[34] Home and community-based services authorities at section 1915 of the Social Security Act give states the option to provide a robust array of services and supports to facilitate beneficiary independence and community integration. Each authority has specific functional eligibility requirements. For example, 1915(c) and 1915(k) Community First Choice programs require individuals to meet an institutional level of care. 1915(i) requires individuals to meet state-defined needs-based criteria.

[35] An "in-lieu-of" service or setting (ILOS) is only available if it is determined to be a medically appropriate and cost effective substitute for a service or setting covered in the Medicaid or CHIP state plan, and complies with regulatory requirements, including those at 42 CFR 438.3(e) and the guidance outlined in SMD 23-001. An ILOS must also not violate any applicable federal requirements, including general prohibitions on payment for room and board under title XIX of the Social Security Act. The ILOS must also be approvable through a state plan amendment authorized through the Social Security Act, including sections 1905(a), 1915(i), or 1915(k) of the Social Security Act, or a waiver under section 1915(c) of the Social Security Act, and are subject to the same limitations as those authorities, (e.g., room and board). The ILOS must also comply with other requirements and limitations, including fiscal limitations outlined in 42 CFR 438.3(e) and the guidance outlined in SMD 23-001.

[36] Children's Health Insurance Program (CHIP) health services initiatives (HSIs) are programs aimed at improving the health of low-income children that states can implement with title XXI funding under their CHIP 10% administrative cap. HSIs are permitted through section 2105(a)(1)(D)(ii) of the Social Security Act, and are defined at 42 CFR 457.10. HSIs must include activities that protect the public health, protect the health of individuals, improve or promote a state's capacity to deliver public health services, or strengthen the human and material resources necessary to accomplish public health goals related to improving the health of children.

[37] Center for Medicaid and CHIP Services. "Additional Guidance on Use of In Lieu of Services and Settings in Medicaid Managed Care," Jan 2023. https://www.medicaid.gov/sites/default/files/2023-12/smd23001.pdf

[38] Center for Medicaid and CHIP Services, "Strategies to Address the Opioid Epidemic" (SMDL #17-003), Nov. 1, 2017. https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd17003.pdf.

[39] Center for Medicaid and CHIP Services, Medicaid 1115 Demonstrations Rapid Cycle Report: Medicaid Section 1115 Substance Use Disorder (SUD) Demonstrations: Features of State Approaches to Improve Medicaid SUD Treatment Delivery Systems. Nov. 2022. https://www.medicaid.gov/sites/default/files/2023-02/sud-1115-rcr-features.pdf.

[40] Larimer ME, Malone DK, Garner MD, et al. Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problems. JAMA, 301(13):1349-1357 (2009). https://jamanetwork.com/journals/jama/fullarticle/183666.

[41] Center for Medicaid and CHIP Services, "Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness (SMI) or Children with a Serious Emotional Disturbance (SED)" (#18-011), Nov. 13, 2018. https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.

[42] The ten states are Alabama, the District of Columbia, Idaho, Indiana, Maryland, New Hampshire, Oklahoma, Utah, Vermont, and Washington.

[43] This information was gathered through interviews conducted between August and November 2022 with 32 Medicaid and behavioral health agency officials and reviews of state documentation submitted to CMCS by ten states with approved SMI/SED demonstrations as of November 2022.

[44] Porchak E, Oudshoorn A, Modanloo, ., et al. Permanent Supportive Housing for Those Experiencing Chronic Homelessness with High Health or Social Support Needs: A Scoping Review. Journal of Health Care for the Poor and Underserved 34(4), 1178-1209 (2023). https://muse.jhu.edu/article/912712.