INNOVATIONS & SOLUTIONS
for Ending Unsheltered Homelessness

March 4–6, 2024 | San Francisco, CA | #NAEH2024

3.05 Housing-Related Flexibilities Afforded through Medicaid: The Good, The Bad and The Ugly

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Housing has been identified as a social determinant of health, as individuals experiencing homelessness face significant challenges in accessing care and managing chronic conditions. States can, through Medicaid options and waiver authorities, cover a wide range of health-related social needs. Leveraging Medicaid is promising, but not without its challenges. Although Medicaid and housing programs tend to serve some of the same people, they historically have operated in silos. Each has complex rules and structures, and their institutional cultures differ. And a variety of payment models and different service systems.

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Housing-Related Flexibilities Afforded through Medicaid:

The Good, The Bad and The Ugly

NAEH Annual Conference

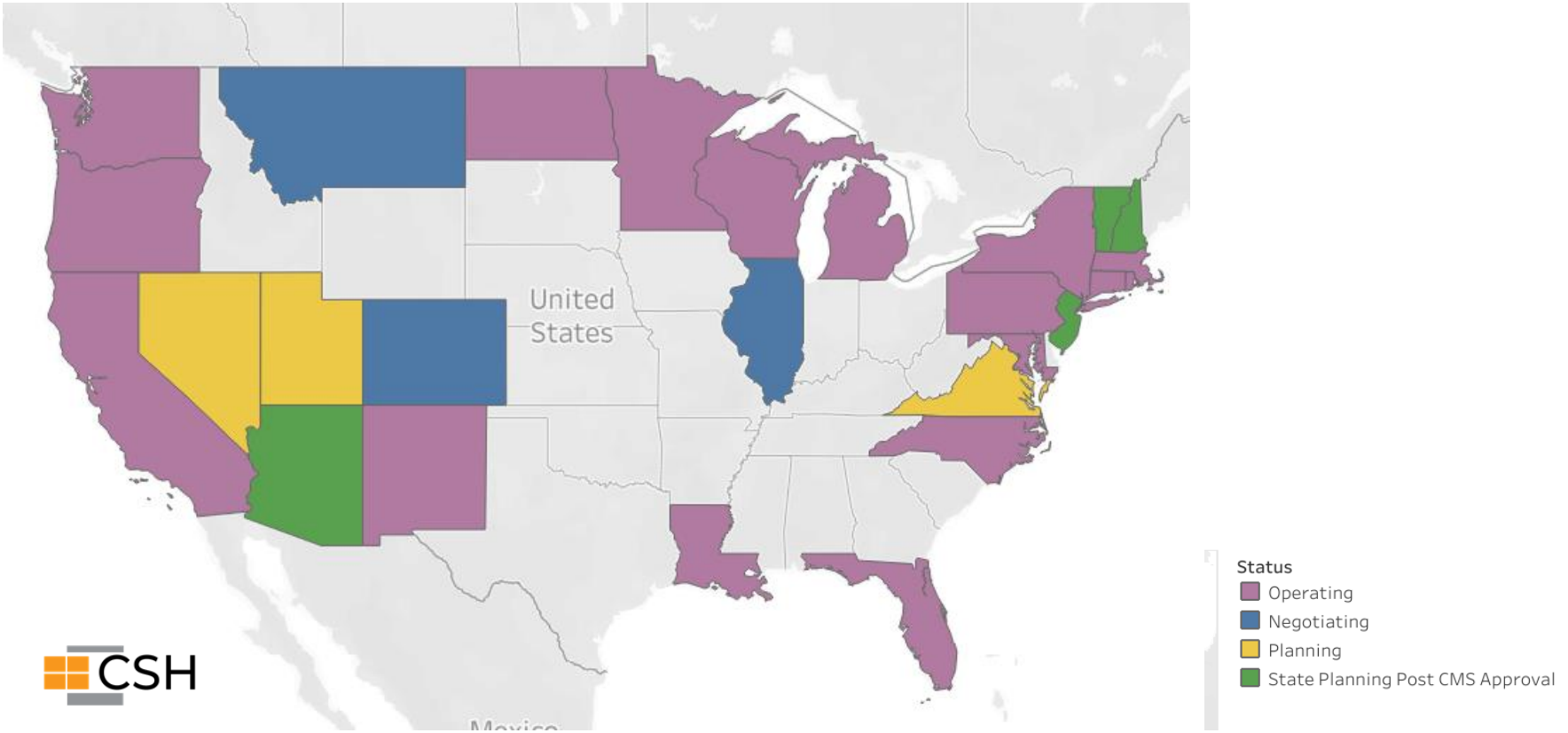
Tracy L Johnson, PhD, Managing Director

Manatt

3/5/2024

Bipartisan Support for Medicaid Coverage of SDOH/HRSNs

States with Medicaid waivers that that pay for housing supports



Source: Corporation for Supportive Housing Medicaid Waivers Map – CSH

Medicaid Focus on SDOH/HSRN began before COVID …

Patient Engagement IT; 4/19/19

How Medicaid Programs Can Revamp SDOH Programs, Community Health

As more Medicaid agencies embrace value-based care, they must reconsider strategies to address the social determinants of health.

Modern Healthcare; 8/3/18

Better State Policy Needed to Address Social Determinants of Health

Health Payer Intelligence; 4/18/19

Medicaid Programs Seek to Address Social Determinants of Health

Social determinants of health are the target of an increasing number of Medicaid programs.

Patient Engagement IT; 6/10/19

Moving Beyond Social Determinants of Health to Community Health

Health payers must move beyond social determinants of health screening to build out community health programming.

Modern Healthcare; 8/3/18

SOCIAL DETERMINANTS ARE CORE OF NORTH CAROLINA'S MEDICAID OVERHAUL

Health Affairs, 8/22/23

Medicaid Is Emerging As A Big Player In Housing, But Success Depends On New Partnerships

Dori Glanz Reyneri

August 22, 2023

… and Medicaid Interest has Accelerated after COVID

Growing interest in health care to address social factors stems from the desire and opportunity to contain costs through improved service utilization and health outcomes

COVID-19 pandemic has underscored the importance of an integrated approach to health

Biden Administration has built an agenda around promoting health equity

Payers are changing benefit policies: housing is healthcare

Medicaid enrollment of low-income adults with complex health and social needs is increasing

Research highlighting importance and opportunity to address SDOH is growing

CMS Framework for Health Related Social Needs (HRSN)

2023 HRSN Coverage Table

CMS supports states in addressing HRSN through coverage of clinically appropriate and evidence-based HRSN interventions

Coverage of Health-Related Social Needs (HRSN) Services in Medicaid and the Children's Health Insurance Program (CHIP)
November 2023

Health-related social needs (HRSN) are an individual's unmet, adverse social conditions that contribute to poor health outcomes. These needs, when unmet, can drive lapses in coverage and access to care, higher downstream medical costs, worse health outcomes, and perpetuation of health inequities, particularly for children and adults at risk for poor health outcomes, and individuals in historically underserved communities. By addressing HRSN, state Medicaid agencies can help their enrollees stay connected to coverage and access needed health care services. The Centers for Medicare & Medicaid Services (CMS) supports states in addressing HRSN through coverage of clinically appropriate and evidence-based HRSN interventions, care delivery transformations including improvements in data sharing, and performance measurement to create accountability for HRSN screening and connecting to needed supports as part of successful care management. States can address HRSN through a variety of Medicaid authorities, including state plan authorities, section 1915 waivers, managed care in lieu of services and settings (ILOSs) and section 1115 demonstrations.

This document lists HRSN services and supports considered allowable under specific Medicaid and Children's Health Insurance Program (CHIP) authorities and provides a discussion of the relevant considerations for each authority. The allowable HRSN services and supports enumerated here are based on robust evidence of strengthening coverage and improving downstream health outcomes, cost, and/or equity. All interventions must be evidence-based and medically appropriate for the population of focus based on clinical and social risk factors. States have flexibility to propose clinically focused, needs-based criteria to define the medically appropriate population, subject to CMS approval.[1] These services will be the choice of the enrollee; enrollees can opt out anytime; and provision of these services does not absolve the state or managed care plan of its responsibility to provide coverage for other medically necessary services. Medicaid-covered HRSN services and supports must not supplant the work or funding of another federal or state non-Medicaid agency and must be integrated with existing social services and housing assistance. Under Medicaid authorities, CMS will not approve federal financial participation payments for the costs of room and board outside of specifically enumerated care or housing transitions,[2] nor may CMS approve services that include room (i.e., rent and utility assistance) and board (i.e., meals or nutrition prescriptions) beyond durations specified below[3]. There are no time limitations to other services, unless otherwise specified. Under no circumstances will a state or managed care plan be permitted to condition Medicaid or CHIP coverage, or coverage of any benefit or service, on receipt of HRSN services. There are additional beneficiary protections, guardrails, and requirements for programming under specific authorities. For example, for states interested in pursuing section 1115 authority for HRSN services, CMS will impose limits on HRSN expenditures, such as establishing a ceiling on overall HRSN funding, and requirements to

[1] Examples of such include high-risk children, high-risk pregnant individuals, individuals who are or are at risk of becoming homeless, individuals with serious mental illness (SMI) and/or substance use disorder (SUD), and individuals experiencing high-risk care transitions (including transitions from institutional care or hospitals for people with disabilities and older adults).
[2] Allowable transitions include out of institutional care (NFs, IMDs, ICFs, acute care hospital); out of congregate residential settings such as large group homes; individuals who are homeless, at risk of homelessness, or transitioning out of an emergency shelter as defined by 24 CFR 91.5; out of carceral settings; and individuals transitioning out of the child welfare setting including foster care.
[3] For additional information on the availability of Medicaid funding for housing and nutritional supports that are not considered room and board, see https://www.medicaid.gov/sites/default/files/2022-01/sho21001_0.pdf

Page 1 of 7

2021 State Medicaid Director Letter

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

SHO# 21-001
RE: Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH)

January 7, 2021

Dear State Health Official:

The purpose of this State Health Official (SHO) letter is to describe opportunities under Medicaid and CHIP to better address social determinants of health (SDOH)[1] and to support states with designing programs, benefits, and services that can more effectively improve population health, reduce disability, and lower overall health care costs in the Medicaid and CHIP programs by addressing SDOH. This letter describes: (1) several overarching principles that CMS expects states to adhere to within their Medicaid and CHIP programs when offering services and supports that address SDOH; (2) services and supports that are commonly covered in Medicaid and CHIP programs to address SDOH; and (3) federal authorities and other opportunities under Medicaid and CHIP that states can use to address SDOH. A table that summarizes the information on key federal authorities for addressing SDOH is also included in an appendix.

Medicaid and the Children's Health Insurance Program (CHIP) provide health coverage to over 76 million low-income Americans, including many individuals with complex, chronic, and costly care needs. Many Medicaid and CHIP beneficiaries may face challenges related to SDOH, including but not limited to access to nutritious food, affordable and accessible housing, convenient and efficient transportation, safe neighborhoods, strong social connections, quality education, and opportunities for meaningful employment. There is a growing body of evidence that indicates that these challenges can lead to poorer health outcomes for beneficiaries and higher health care costs for Medicaid and CHIP programs and can exacerbate health disparities for a broad range of populations, including individuals with disabilities, older adults, pregnant and postpartum women and infants, children and youth, individuals with mental and/or substance use disorders, individuals living with HIV/AIDS, individuals living in rural communities, individuals experiencing homelessness, individuals from racial or ethnic minority populations,

[1] The Centers for Disease Control and Prevention (CDC) refers to SDOH as "conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes." See https://www.cdc.gov/socialdeterminants/about.html for CDC information on SDOH, including research on the impact of SDOH on health outcomes and health care costs. Healthy People 2030, which is managed by the Office of Disease Prevention and Health Promotion in the U.S. Department of Health and Human Services (HHS), uses a place-based framework that highlights the importance of addressing SDOH. Healthy People 2030 was released in 2020 and sets data-driven national objectives to improve health and well-being over the next decade. Healthy People 2030 SDOH objectives can be found here.

Sources: hrsn-coverage-table.pdf (medicaid.gov) and sho21001_0.pdf (medicaid.gov)

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Medicaid Coverage for Housing Related Services: "A Bridge"

"The key with coverage of short-term housing related costs is … seamlessly bridg[ing] into the way HUD rental assistance works." Richard Cho, HUD Secretary

** NEW **

Coverage Options that do NOT need 1115 waiver		NEW Coverage Options thru 1115 Waivers	
HOUSING SUPPORTS ✓ Housing Transition and Navigation Services ✓ Moving Costs and Deposits ✓ Tenancy and Sustaining Services	**HOME MODIFICATIONS** Home remediations & accessibility	**Cross-Sector Collaboration, Capacity Building & Infrastructure**	**Short-Term "Room & Board"** ✓ Short-Term rental or other transitional housing ✓ Medical respite/ recuperative care/ post-hospitalization housing ✓ Utilities

hrsn-coverage-table.pdf (medicaid.gov)

State Spotlights: Variability in Implementation

California: Community Supports

- California provides 14 Community Support services, many related to housing, through managed care plans, including:
  - Housing Transition and Navigation
  - Housing Deposits
  - Housing Tenancy and Sustaining Services
  - Short-Term Post-Hospitalization Housing
  - Home Modifications
- Most services are authorized using managed care (1915b) authority; services with room and board are authorized by 1115 waiver

Hawaii: Community Integration Services

- Waiver authorized provision of housing benefits to individuals who:
  - Have complex physical and/or behavioral health needs, and
  - Who are homeless, at risk of homelessness or who have a history of frequent and/or lengthy stays in a nursing facility
- Once enrolled, beneficiaries may receive:
  - Pre-Tenancy Supports
  - Tenancy Sustaining Services
  - Community Transition Services Pilot Program

North Carolina: Healthy Opportunities Pilots

- Waiver authorized "Healthy Opportunities Pilots", operated now in two regions of the State
- To qualify, individuals must have a co-occurring physical/behavioral need (that varies by population group) and social risk factor across four domains (housing, food, interpersonal violence and toxic stress)
- North Carolina has authority to cover a robust set of SDOH services. Examples of services include:
  - First month's rent
  - Medical respite
  - Healthy Food Box

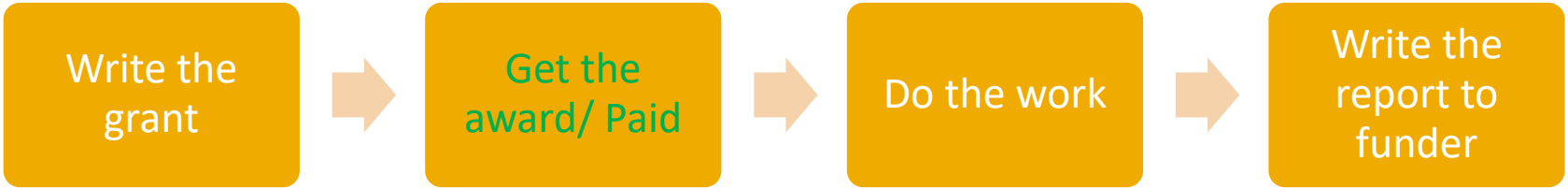
Medicaid Implementation Priorities

North Star: Provide "whole person care"

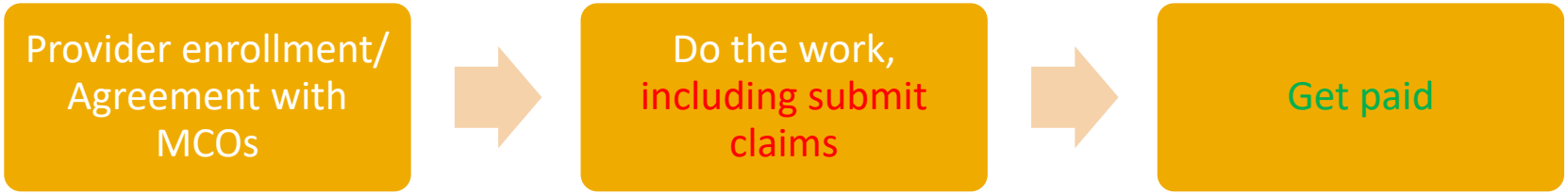
- Identifying people's social needs and addressing them
- Embedding SDOH into broader care coordination strategies
- Building a "provider network" of community-based organizations
- Supporting sustainable investments in community-based interventions
- Evaluating the effectiveness of SDOH/HRSN interventions on health outcomes and health care costs
- Promoting health equity and confronting structural racism
- Enhancing cross-sector financing and accountability mechanisms

Medicaid Payment Processes are very Different than Grants

The grant world, administratively



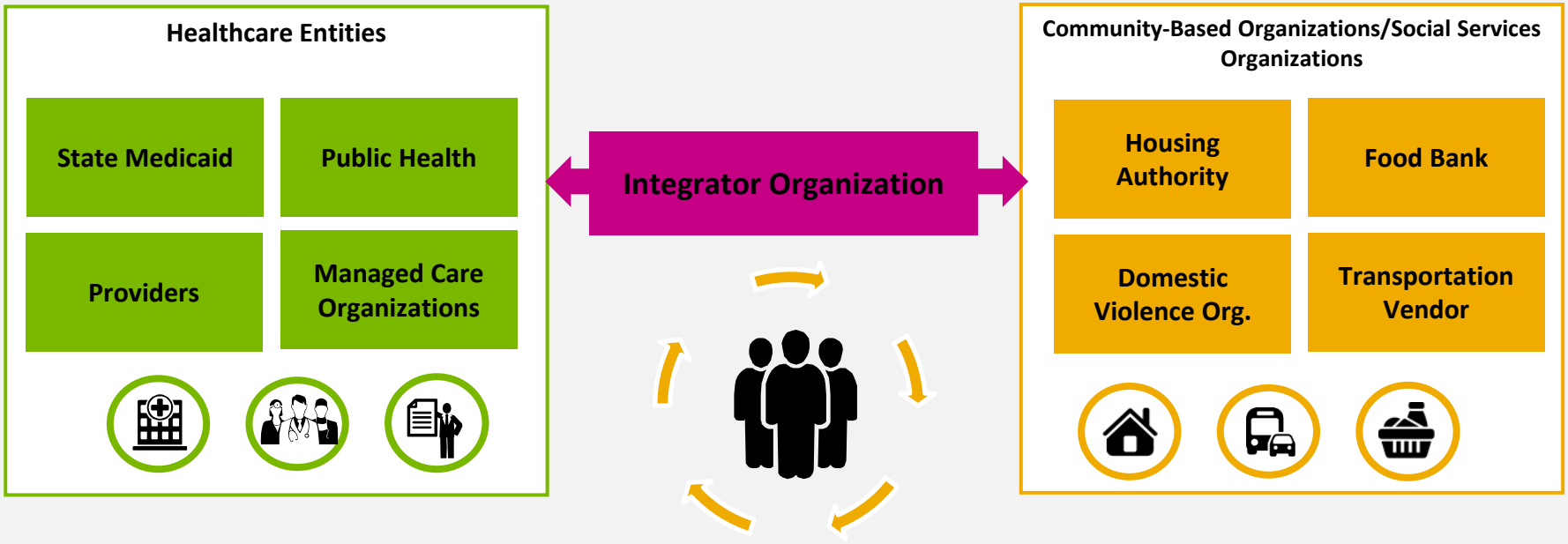
The Health care world administratively



CSH

Implementation Issues: Integrator Organizations

Some states are using integrator organizations to facilitate cross-sector collaboration



Integrator Organization Example

Regional Entity "Integrator" Roles

Regional Entities' Core Functions: First Phase

- Serve as local expert and conduit for state priorities
- Convene and collaborate with community stakeholders (e.g., health plans, providers, hospitals, health systems, local public health departments, CBOs) around planning, training, information sharing
- Support SDOH screening and closed-loop referrals with CBO network
- Develop and execute sustainability plan, including seeking support from other payers
- Track and submit data for reporting

Regional Entities' Core Functions: Second Phase

- Serve as single contracting/billing entity on behalf of member organizations
- Directly provide/contract with other CBOs to provide all approved HRSN services
- Assess CBO capacity and performance
- Distribute seed funding to contracted CBOs (if available)
- Reimburse for services under an 1115 waiver (if applicable)

Similar to recent initiatives in other states:

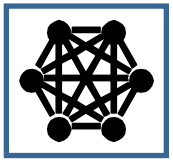
New Jersey | North Carolina | Washington

Regional Entity Considerations

- **Pilot regional entities** before going fully statewide
- **Leverage existing entities,** such as local health departments, health plans, Area Agencies on Aging, and/or high performing CBOs to serve as regional entities
- **Identify seed funding (e.g., state appropriation)** to support regional entities
- **Seek federal funding** through 1115 waiver to support regional entities
- **Require MHPs to contract with and provide investment in regional entities**

Key Questions for Housing Support Providers to Consider

Bridging sectors …



Who are potential health care partners? Is there an integrator?

How will my organization get paid for housing-related services?

What new capabilities does my organization need to partner with health care entities?

How are housing related services best integrated w/ health services?

How do new partnerships with align with my organization's mission?

Examples

Goal	Essential Activities	Key Challenges
Improve Individual & Community Health 	• Identify individuals and communities at risk • Assess individuals' needs • Refer to appropriate providers and programs • Track progress over time	• Earning trust • Lack of standardized assessments • Difficulty connecting social services and healthcare providers
Support Engagement & New Partnerships 	• Co-design with those with lived-experience • Establish common goals • Execute contractual expectations • Design and implement IT services • Conduct meaningful reporting • Create sustainable payment arrangements	• Distinct organizational missions • Lack of standardized contracts, service definitions and prices • Lack of shared systems, data standards, and governance processes • Reliance on one-time funds
Evaluate Outcomes to Build the Evidence Base 	• Design rigorous evaluation • Collect and analyze data and measure service impact (on outcomes, utilization, spend, equity) • Determine service cost to measure ROI	• Need for specific expertise and funding • Complexity of collecting and managing data from variety of sources

Some States/Foundations/Health Plans Offer Provider TA

State Example: Washington

Washington's *Foundational Community Supports* program, authorized through the State's 1115 waiver, offers supportive housing and supported employment services to high-need Medicaid enrollees.

A single third-party administrator—Amerigroup—provides administrative oversight of:

- The housing and employment service provider network;
- Service authorization;
- Claims payment;
- Encounter tracking/reporting.

Foundation Example: CHCF

In early 2023, the California Health Care Foundation funded the Corporation for Supportive Housing to hold a Medi-Cal Academy, a 10-session training series delivered by webinar, for housing and homeless service agencies interested in contracting with MCPs to provide housing-related Community Supports. in implementing the housing-related Community Supports available through CalAIM.

The sessions were recorded and slides are available for download.

Health Plan Example: UnitedHealthcare

To support the delivery of a suite of SDOH-related services for its high-need Medicaid population, UnitedHealthcare has created on-the-ground partnerships with a spectrum of community providers (e.g. faith-based providers and non-profits) as part of its "My Connections" program.

Washington State 1115 Waiver and Operational Protocols;. United Healthcare: MyConnections; Medi-Cal Academy for Homeless Service Providers - California Health Care Foundation (chcf.org)*; ;*

Get Involved: Provide Feedback on State MCO Contracts

EXAMPLE: Contract & Financial Strategies

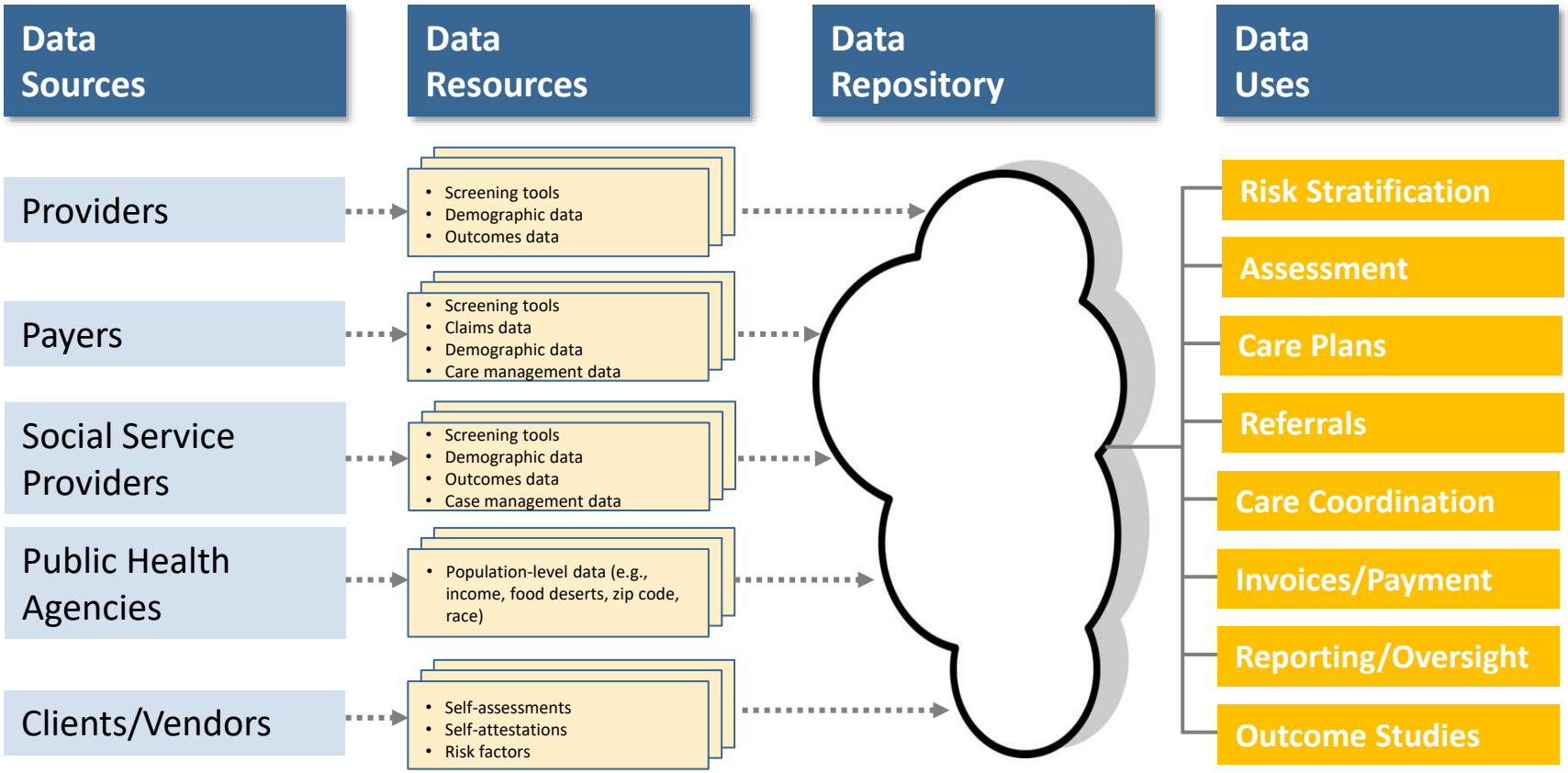
Add **MHP contractual provisions** focused on bolstering the CBO/MHP relationship:

- Require/encourage direct contracts with CBOs for high-value services
- Require/encourage investments in common infrastructure; *or*

Draw upon a variety of funding strategies to **encourage** MHPs to build relationships with CBOs

Get Involved: Build Shared Client Support Systems

Data from diverse sources can be combined in new ways to enable innovative, meaningful applications to address SDOH.



GOOD SAMARITAN SHELTER
SANTA BARBARA COUNTY

ALEXIS NSHAMAMBA, DIRECTOR OF HOUSING & QUALITY ASSURANCE

good samaritan

GOOD SAMARITAN

OUR MISSION

Our mission is to provide emergency, transitional, and supportive services to the homeless and those in recovery throughout the greater Santa Maria Valley and Central Coast.

In 2023, we served 4,420 unduplicated folks throughout Santa Barbara County

TYPES OF PROGRAMS OPERATED BY GOOD SAMARITAN

- Congregate Shelter
- Non-Congregate Shelter
- Street Outreach
- Transitional Housing

- Housing Disability & Advocacy Program
- Rapid Rehousing
- Scatter Site Supportive Services (attached to Voucher Programs)
- Permanent Supportive Housing

- Recuperative Care Programs
- Mental Health Services
- Pre-Trial Navigation Services

EXAMPLES OF FUNDING SOURCES

- CONTINUUM OF CARE
- VETERANS AFFAIR
- EMERGENCY SOLUTIONS GRANTS
- PERMANENT LOCAL HOUSING ALLOCATION PROGRAM
- AMERICAN RESCUE PLAN ACT
- HOMELESS HOUSING, ASSISTANCE, AND PREVENTION

THE GOOD

SERVICE
FULFILLMENT

1. People are getting the services they need.
2. Opportunity for ongoing funding.
3. Housing is finally being regarded as fundamental.
4. Expansion of multi-disciplinary teams.
5. More strategic case management.
6. Braiding funding — making grants stretch!

THE FOLKS WE ARE SERVING

637

Enhanced Care Management

96

Housing Deposit Program

262

Housing Transition Navigation Services

175

Housing Tenancy and Sustaining Services

1,107

Sobering Center

113

Recuperative Care

THE BAD

ADMINISTRATIVE OVERLOAD

1. Change is hard.
2. Administrative teams need to bulk up.
3. If you are unfamiliar with HIPAA compliances, this would be a learning curve.

THE UGLY

COMPLEX
COMPLIANCE

1. Reporting can be tricky.
2. The fiscal mindset must change.
3. Billing insurance providers is scary.
4. Managing new partner relationships is always complex (Make Managed Care Plans your Best Friend!)

CONCLUSION

Advocates in the homeless services sector have long called for increased support, and now we are gaining traction.

We must do whatever is necessary to provide more support for our unhoused neighbors- including embracing change! The benefit will outweigh the risk and we must prove that we have been doing healthcare services for years!

good samaritan
FOR THOSE IN NEED... OUR DOOR IS OPEN.

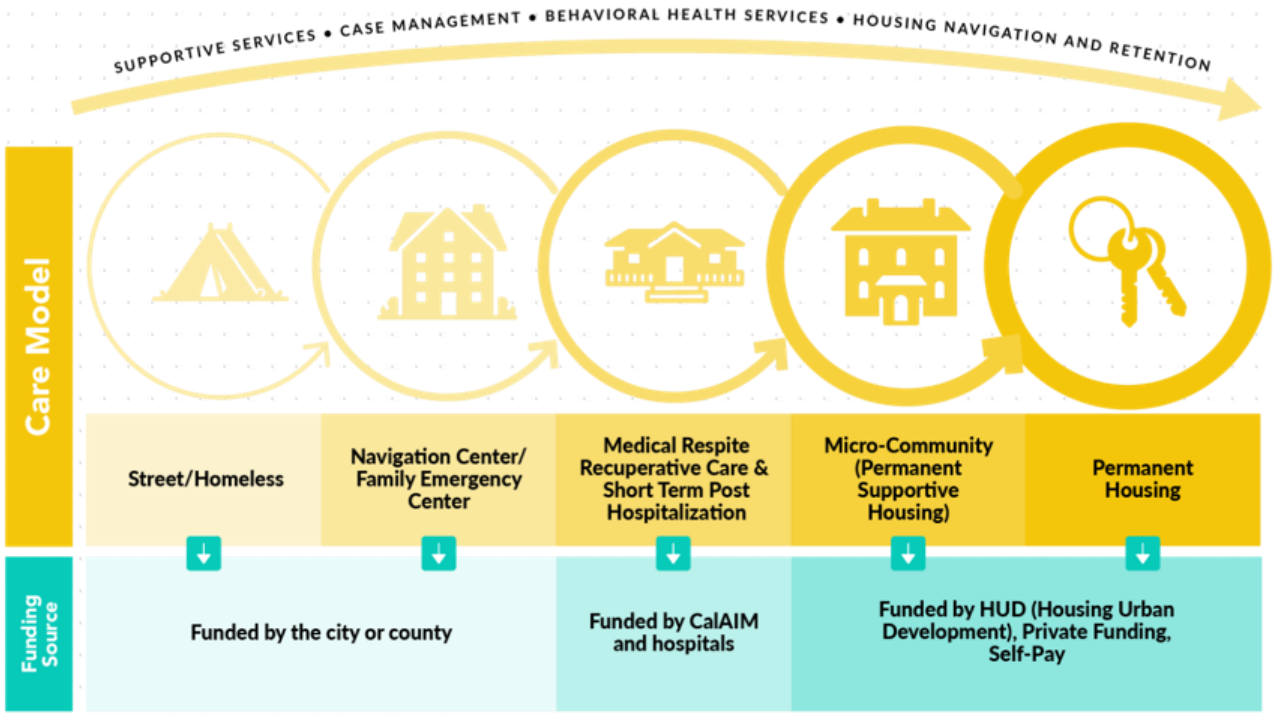
ILLUMINATION FOUNDATION

DISRUPTING THE CYCLE OF HOMELESSNESS

PRESENTED BY

Pooja Bhalla, DNP, RN
CEO, Illumination Foundation

Street 2 Home System of Care



ILLUMINATION FOUNDATION

DISRUPTING THE CYCLE OF HOMELESSNESS

Illumination Foundation Sites

5	4	1	2	1	1	21	197
Medical Respite/ Recuperative Care	Family Shelters	Project Homekey Site	Multi-Service Centers	Navigation Center	Modular Housing (LifeArk)	Micro-communities	Scattered Sites

ifhomeless.org

@ifhomeless

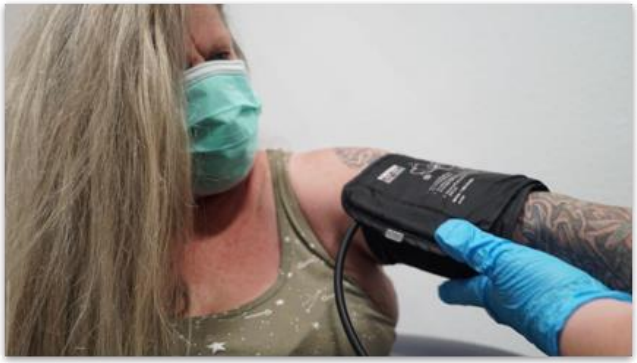
ILLUMINATION FOUNDATION

DISRUPTING THE CYCLE OF HOMELESSNESS

Fullerton Recuperative Care

The state-of-the-art facility of its kind providing end-to-end services for the most vulnerable segments of those experiencing homelessness, including:

- Recuperative Care/Medical Respite
- Short-Term Post-Hospitalization
- Primary Care
- Mental Health
- Substance Use Counseling
- Community Supports Services



ifhomeless.org

@ifhomeless

A Win-Win Partnership

ILLUMINATION FOUNDATION

DISRUPTING THE CYCLE OF HOMELESSNESS

Medical Respite/Recuperative Care

- 150-bed facility
- ADA accessible
- Room and board
- Case management
- Substance use counseling
- Connection to social services
- Housing navigation
- Dental care

IFMG

ILLUMINATION FOUNDATION MEDICAL GROUP

Primary Care Clinic

- Primary care services
- Staff includes: M.D., psychiatrist, nurse practitioner, and behavioral health counselors
- Preventive care services
- Medical screenings
- Illness and injury management
- Chronic disease management
- Behavioral health counseling
- Medication assisted treatment
- Referral to specialty care

ILLUMINATION FOUNDATION

DISRUPTING THE CYCLE OF HOMELESSNESS

CalAIM Service Provider in Four Counties

Orange County - Community Supports

CalOptima Health

Los Angeles County - Community Supports and ECM

L.A. Care HEALTH PLAN

Anthem BlueCross

KAISER PERMANENTE

MOLINA HEALTHCARE

health net

Inland Empire (San Bernardino & Riverside) - Community Supports

IEHP A Public Entity

Inland Empire Health Plan

MOLINA HEALTHCARE

Community Supports Capabilities

Services Offered
Housing Transition Navigation Services
Housing Deposits
Housing Tenancy and Sustaining Services
Recuperative Care (Medical Respite)
Short-Term Post-Hospitalization
Day Habilitation

Partnerships for Action: California Health Care & Homelessness Learning Collaborative

California Health Care Foundation

ILLUMINATION FOUNDATION
DISRUPTING THE CYCLE OF HOMELESSNESS

CalOptima Health

OC health CARE AGENCY

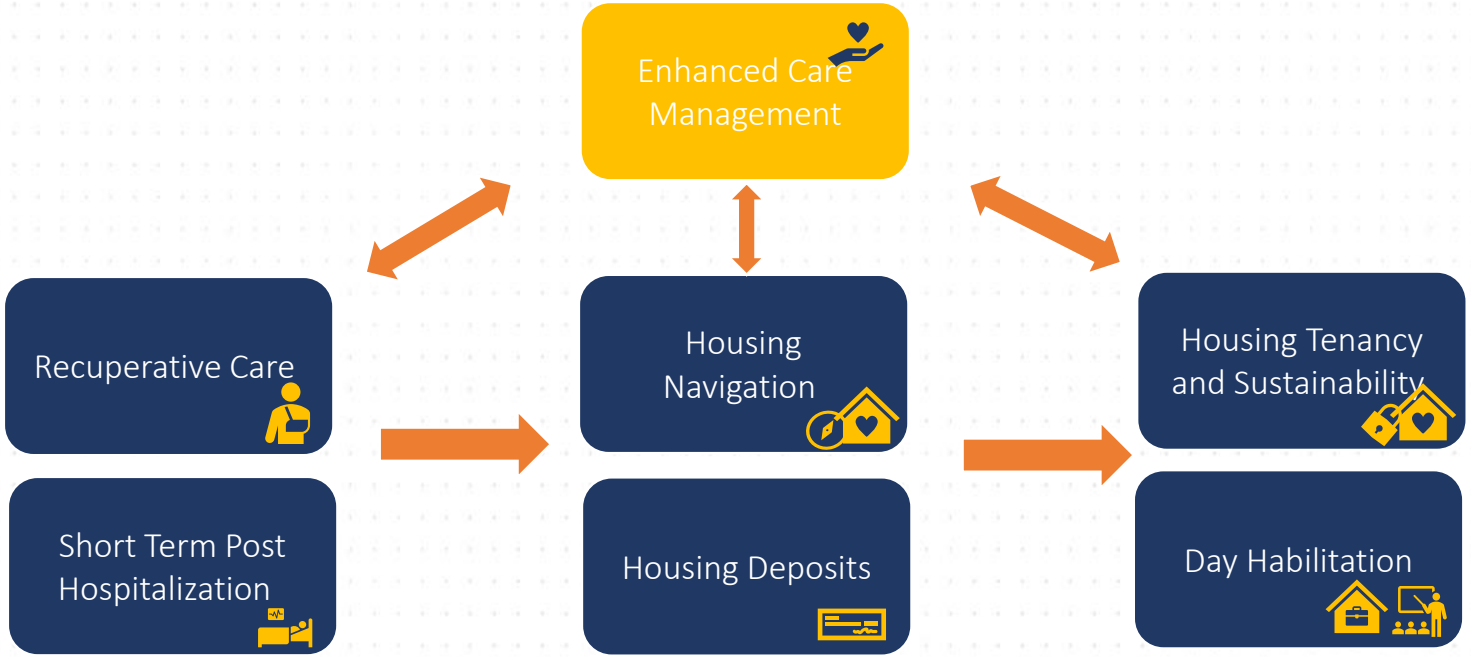
Katelyn Taubman, Illumination Foundation staff member with lived experience, was a Collaborative Advisor for the Center for Health Care Strategies review panel.

ILLUMINATION FOUNDATION

DISRUPTING THE CYCLE OF HOMELESSNESS

DHCS

CalAIM Continuum at IF



Key Takeaways from Learning Collaborative

- Housing Partnerships
- Data Sharing
- Need for Productive Partnerships

What's Working

- Better Relationships with Plans
- Improved Services to Patients
- Better-informed Partners
- Greater System Integrations

Source: Lesson Learned: CalAIM Implementation of Recuperative Care Services

Challenges

- Significant Administrative Burden
- Low Reimbursements
- High Clinical Needs
- Limited Lengths of Stay Amid Scarcity of Housing Opportunities

Source: Lesson Learned: CalAIM Implementation of Recuperative Care Services

Story and photo used with Roger's permission.

PATIENT STORY

Roger is a patient who successfully transitioned from a hospital stay to recuperative care to short-term post-hospitalization housing (another CalAIM Community Support) and then to permanent housing (with ongoing services).

Upon intake at the recuperative care program, Roger was very concerned about his health, legal problems, housing, and the denial of income from SSDI. During his stay, staff were able to help Roger with medication management, and obtain Medi-Cal coverage, a primary care provider, and vital documents. He was able to clear his warrants with the help of the homeless court and was matched to housing.

Roger was able to work on budgeting, stress management, and tenancy skills while in short-term post-hospital housing, and then successfully moved into an apartment with a housing voucher where he continues receiving tenancy and sustainability services.

Questions and Comments

Tracy L Johnson, PhD,
Managing Director, Manatt

Alexis Nshamamba
Director of Housing & Quality Assurance, Good Samaritan

Pooja Bhalla, DNP, RN
CEO, Illumination Foundation