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Using Medicaid to Finance and Deliver Services in Supportive Housing: Challenges and Opportunities for Community Behavioral Health Organizations and Behavioral Health Authorities

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Executive Summary

Behavioral health authorities and community behavioral health organizations are increasingly examining ways to meet the needs of individuals with mental illnesses (MI) and/or substance use disorders (SUD). Permanent Supportive Housing (PSH) is a cost-effective, evidence-based intervention that addresses the need among many individuals, providing permanent affordable housing and community-based, person-centered services. As states increase their PSH capacity, they are also seeking to leverage Medicaid as a cost-effective source to finance and deliver the services component of PSH.

This paper discusses the policy context driving the inclusion of more integrated PSH options within state and local behavioral health authorities, and builds on recent federal guidance regarding Medicaid reimbursement for housing-related services. State behavioral health authorities, Medicaid agencies and organizations serving people with MI and/or SUD each play a critical role working together to identify, pay for, and implement these types of services.

Behavioral health authorities can begin to explore strategies to better target resources and ensure a range of housing and service options that include integrated approaches and best practices, like PSH. This requires the expansion of partnerships with state/local housing agencies to better access mainstream affordable housing resources and the preservation of limited behavioral health system resources currently used to pay for housing. It also means working with state Medicaid agencies to coordinate reimbursement of services for individuals living in PSH, building the system's capacity to support providers to effectively deliver community-based services in PSH settings. Assessing housing-related service needs, current funding streams and options to maximize Medicaid coverage to fill gaps and redirect non-Medicaid resources to pay for what Medicaid cannot, are critical steps state behavioral health and Medicaid agencies can engage to ensure people have access to the full range of services they need to succeed in PSH.

As states engage in these activities, there are preparations that must take place on the organization level. Many behavioral health organizations will need to assess how changes in affordable housing development and payment for services may impact their current and future role as a developer, housing operator and service provider. Furthermore, as Medicaid becomes a payer for housing-related services and supports, organizations must adapt to reimbursement for services delivered to individuals rather than program-based funding to operate bundled housing and service programs. Many organizations will need to modify their business strategies in response to these changes and some will need to consider the business and provider requirements associated with becoming a Medicaid provider. Organizations will also need to develop strategies for expediting and maintaining Medicaid eligibility and enrollment for the individuals they serve.

State leaders can undertake many activities to support organizations through this transition. For example, they can set adequate rates for Medicaid reimbursable services, work to encourage flexibility within managed care arrangements and provide technical assistance and training to meet workforce development needs so providers have the skills and expertise to implement best practice housing-

related services. This paper offers strategies for behavioral health authorities and organizations to consider in these areas.

Overview and Purpose

Public behavioral health¹ authorities and community behavioral health organizations are increasingly recognizing the critical role of permanent affordable housing in supporting individuals' recovery from MI and/or SUD. Many have endeavored to make available a range of housing and service options consistent with the needs, preferences and what is considered effective for each respective population at various stages of treatment and recovery. Yet access to an array of community-based services matched with permanent affordable housing for people with MI and/or SUD remains a major challenge.

PSH is recognized as an evidence-based practice by the Substance Abuse and Mental Health Services Administration (SAMHSA) that combines lease-based, permanent affordable housing in the community with voluntary, flexible and individualized services to ensure successful tenancies.² While earlier studies documented PSH's alignment with individual housing preference and choice among many people with MI,³ the model has gained favor over the last decade due in large part to research demonstrating its cost effectiveness, particularly among people with MI and/or SUD who often have co-occurring health conditions, have experienced homelessness and are frequent users of costly institutional and emergency care.⁴ Research has also demonstrated positive outcomes for PSH participants on housing stability, health and behavioral health measures.⁵

Core Components of Permanent Supportive Housing (PSH)

- ✓ Choice of housing, including type, location and who individuals lives with.
- ✓ Separation of roles related to housing management and services.
- ✓ Housing is decent, safe and affordable (i.e., tenants pay no more than 30 percent of their income toward rent and utilities).
- ✓ Housing is integrated in the community.
- ✓ Individuals have full tenancy rights in accordance with a standard lease or occupancy agreement.
- ✓ Housing is accessible to individuals without having to demonstrate housing "readiness."
- ✓ Individuals are offered a range of flexible, consumer-driven services to transition to and successfully maintain housing.

While PSH may have the most evidence emanating from and be more widely accepted as the preferred model within mental health and homelessness systems, several states are now implementing PSH to serve a cross-disability population with some of the most complex challenges.

¹ Behavioral health is used throughout this paper to refer to mental illness, substance use and co-occurring disorders.

² Substance Abuse and Mental Health Services Administration. (2010). *Permanent Supportive Housing Evidence-Based Practices Kit*. Rockville, MD: SAMHSA.

³ Carling, P. et al., (1987). *Housing and Community Integration for People with Psychiatric Disabilities*. Burlington, VT: Center for Community Change through Housing and Support; Tanzman, B. (1993). An overview of surveys of mental health consumers' preferences for housing and support services. *Hospital and Community Psychiatry* 44(5), 450-455; Yeich, S. et al., (1994). The case for a 'Supported Housing' approach: A study of consumer housing and support preferences. *Psychosocial Rehabilitation Journal* 18(2): 75-86.

⁴ Culhane, D. P., Metraux, S., Hadley, T. (2002). Public service reductions associated with placement of homeless persons with severe mental illness in supportive housing. *Housing Policy Debate*, 13(1), 107-163; Larimer, M.E. (2009). Health care and public service use and costs before and after provision of housing for chronically homeless persons with severe alcohol problems. *The Journal of the American Medical Association*, 301(13), 1349; Chalmers McLaughlin, T. (2010). Using common themes: Cost-effectiveness of permanent supported housing for people with mental illness. *Research on Social Work Practice*, 21(4), 404-411.

⁵ Rog, et al. (2013). Permanent supportive housing: Assessing the evidence. *Psychiatric Services* 65(3):287-94; Padgett, et al. (2011). Substance use outcomes among homeless clients with serious mental illness: Comparing Housing First with treatment first programs. *Community Mental Health Journal*, 47(2), 227-232. Wolitski, et al. (2009). Randomized trial of the effects of housing assistance on the health and risk behaviors of homeless and unstably housed people living with HIV. *AIDS and Behavior*, 14(3), 493-503.

This includes individuals and families who are at risk of or are experiencing homelessness or chronic homelessness; individuals exiting institutions such as hospitals, jails, correctional facilities, adult care homes and treatment centers; and youth aging out of foster care. Additionally, PSH is often featured as one option among a range of housing and service models which include Recovery Housing and other models considered effective at various stages of treatment and recovery within SUD systems. Housing First and other low-demand models of PSH, for example, are increasingly accepted as viable alternatives for people with SUD who may have difficulty accessing and/or succeeding in abstinence-based programs due to factors like co-occurring MI and chronic homelessness.⁶

Increasingly, behavioral health authorities are seeking to ensure that a range of quality housing and service options exist that reflect the needs and choices of the individuals being served throughout the recovery process, rather than treating one housing model or approach as superior to others. However, recent enforcement of federal community integration laws, state and federal policies implementing Medicaid cost containment and rebalancing, and new settings requirements for the delivery of home and community-based services have led many states to examine ways in which they can specifically incorporate integrated PSH options within their housing and services continuums. This is especially true where lack of availability and/or access to these types of options, due in part to reliance on congregate or institutional settings, seriously limits the housing choices of people with behavioral health needs. As part of these efforts, states are increasingly seeking to leverage Medicaid as a cost-effective source to finance and deliver housing-related services—defined as the range of flexible services and supports that individuals with behavioral health disorders need to transition to and maintain housing in settings like integrated PSH. In order to do this, state behavioral health authorities, Medicaid agencies and providers must work together to identify, finance and implement these types of services.

This paper presents the policy context driving the inclusion of integrated PSH options within state and local behavioral health authorities serving people with MI and/or SUD, describes the issues behavioral health organizations must consider using Medicaid as a source to finance and deliver services in integrated PSH settings, and highlights the opportunities that exist for state and local policymakers to align and achieve the goals of various federal policy initiatives.

The paper builds on recent federal guidance regarding Medicaid reimbursement for housing-related activities and services for people with disabilities,⁷ describing the types of services and interventions that people with behavioral health disorders need in order to access and maintain housing and offers a review and comparative analysis of specific Medicaid authorities and demonstrations that can be used to finance these services, along with strategies for covering the supports that Medicaid cannot pay for. New opportunities created in the Affordable Care Act (ACA) that expand Medicaid eligibility and access to services, particularly for people with SUD, are explored as ways for more people with MI and/or SUD to receive the services they need to be successful in housing. Given the unique policy context and financing issues related to other housing options such as Recovery and Transitional Housing models

⁶ Burt, M., et al. (2004). *Strategies for Reducing Chronic Street Homelessness: Final Report*. Washington, DC: U.S. Department of Housing and Urban Development.

⁷ CMS Informational Bulletin on Coverage of Housing-Related Activities and Services for Individuals with Disabilities. Available online at: www.medicaid.gov/federal-policy-guidance/downloads/CIB-06-26-2015.pdf

for individuals with SUD, this paper focuses primarily on policy and service financing issues related to integrated PSH settings.

State case studies and lessons learned from states and community behavioral health organizations who are moving toward or are already succeeding at the delivery of Medicaid-financed services in PSH are included and highlight promising practices for utilizing contracting, payment and other mechanisms to support these efforts within the current Medicaid and managed care financing environment.

Table 1 identifies best practice housing-related services and interventions, along with the three phase(s) or timeframe(s) during which these services generally occur (i.e., preparation for, move-in and maintenance of housing). This planning tool also identifies considerations for Medicaid reimbursement for these interventions, including under what circumstances they could be considered Medicaid reimbursable and what interventions would need to be covered by other resources. Specific population, referral source or health conditions eligibility criteria should be considered prior to using this as a planning tool.

- What existing Medicaid and non-Medicaid services incorporate these functions, for whom and with what provider administrative and professional requirements?
- What eligibility (by covered population) and enrollment requirements exist for these services?
- What it will take to incorporate person-centered planning?
- What service and management arrangements, including care coordination and/or managed care are in place for these functions to be carried out “seamlessly” across the three phases of housing?
- How will these support arrangements meet medical necessity?
- What opportunities exist and what are gaps in terms of services, categorical limits, time limits, continuity issues or challenges for your organization or community?
- While not a service function, what are the parallel housing activities that match up across each of the housing phases and are there opportunities to streamline? For example, as systems invest in more integrated housing approaches like PSH that maximize Medicaid reimbursement for housing-related services, it may become more efficient to centrally manage activities like outreach and marketing to housing providers (e.g., landlords, developers, PHAs) to create a broader "pool" of housing units. Service providers/referring agencies can then facilitate individuals' access based on assessed needs and preferences, rather than taking a provider by provider approach to locating housing, which limits choice and can be an expensive and time consuming process.

Completing this type of analysis allows behavioral health system leaders and providers to shift their attention to analyzing Medicaid authorities and demonstrations and to conduct a cost and revenue analysis which defines where true gaps exist and allows for the development of strategies to best fill gaps in housing-related services coverage through re-directing federal, state and local funds, re-ordering priorities, improving enrollment and refining service strategies.

Table 1: Housing-Related Service Arrangements Planning Tool

Housing-Related Interventions	PSH Phase			Service/Service Arrangement & Potential for Medicaid Coverage
	Preparation for Housing	Move-In	Maintenance of Housing	
Outreach and engagement, assessment of housing preferences and barriers, housing search assistance, assistance gathering documents and applying for housing, making reasonable accommodation requests, completing subsidy applications and re-certifications, identifying resources to cover security deposits/move-in costs, development of initial housing support and crisis plans	✓			The preparation for housing phase includes interventions to assist with pre-tenancy, as well as ongoing engagement around housing preference and choice. Staff are typically assigned to do in-reach and transition planning if a person is being discharged from some type of inpatient, criminal justice or group setting, or to do outreach if a person is homeless or not engaged in the system. While these may be Medicaid coverable interventions, often these tasks are performed with people not yet enrolled in Medicaid or a Medicaid program. In managed systems, this assignment could be done by a managed care organization (MCO)/administrated services only (ASO). If these tasks are conducted as outreach and are part of a person's treatment/service plan and conducted in accordance with the requirements of the specific Medicaid plan (for persons not yet enrolled in Medicaid only with specific presumptive eligibility provisions until the person is enrolled) they could be coverable within limits. If in-reach, the arrangements may be covered by Medicaid as well as other sources.
Moving assistance		✓	✓	These tasks include arranging for and supporting a person with the initial move into housing and are considered coverable individual housing transition services under Medicaid. In some circumstances, it may be necessary to perform these tasks when an individual must move from one community-based housing situation to another if, for example, the initial housing situation does not work out.
Acquiring furnishings/supplies, budgeting, maintaining a household: shopping, cooking, cleaning, repairs, upkeep		✓	✓	These tasks include teaching or coaching, assistance with decision-making and priority setting and are typically part of a Medicaid coverable service intervention that falls under the category of "skills acquisition." For some persons with physical, cognitive or developmental limitations, it may also include personal assistance covered under Medicaid.
Orientation to neighborhood and transportation		✓	✓	These tasks may also fall under "skills acquisition" or personal assistance; Medicaid plans vary on transportation assistance.
Eviction prevention (paying rent on time, meeting other lease requirements)			✓	These tasks may also fall under "skills acquisition" (e.g., budgeting and understanding lease obligations, and assistance with decision making and negotiation.)
Eviction prevention (conflict resolution)			✓	These tasks may be Medicaid coverable under services that include illness management and recovery, relapse prevention, individual counseling and de-escalation of crises.
Peer or other natural supports	✓	✓	✓	Most Medicaid state plans now include peer support for specific target populations and the service can include assistance with skill acquisition, decision-making and use of community and personal supports, relapse prevention and crisis prevention. In addition, most states recognize and assure the availability of support groups. They are likely not Medicaid reimbursable but are vital to persons making a transition to community living and to personal recovery and relapse prevention.
Education/training on tenant and landlord rights and responsibilities, coaching and assistance to develop/maintain relationships with landlords/neighbors to promote housing success	✓	✓	✓	These tasks may be coverable by Medicaid, and require that staff working with persons to support them in maintaining housing be familiar with tenant and landlord responsibilities.
Linkage to and provision of services and supports necessary for a person to live in their own home	✓	✓	✓	These tasks may be coverable by Medicaid and include care coordination (authorization, monitoring and linkage) and direct services for in-home personal assistance, home health and teaching the use of adaptive equipment and modifications and community-based health care, substance use and mental health treatment, supported employment and other services that better enable a person to live in their own home.
Outreach and advocacy with housing providers to participate and remain in a rental program (federal, state or local)	✓	✓	✓	This task is essential for any integrated PSH program and is typically not a Medicaid reimbursable activity, although it may be included as a responsibility of a service provider. In many systems, including managed care operated systems taking PSH to scale, these tasks have been assigned to a housing organization (e.g., a subsidy administrator) or to a centralized unit dedicated to PSH management (e.g., to manage housing referrals and eligibility, etc.)
Rental assistance/contingency costs management	✓	✓	✓	This includes assistance with move-in costs and specific housing-related costs (deposits, rent arrearages, damages, rental assistance and other onetime housing related costs). These expenses are only partially Medicaid coverable under very

Policy Context for Inclusion of Integrated PSH Options within States

Enforcement of Federal Community Integration Laws

Perhaps the greatest driving factor behind expansion of integrated PSH over the last five to six years, particularly within public mental health systems, has been the enforcement of disability-related federal community integration law within states. Title II of the Americans with Disabilities Act (ADA), enacted by Congress in 1990, provides the integration mandate that was upheld by the U.S. Supreme Court's decision in *Olmstead vs. L.C.* in 1999. The mandate requires public entities to "administer services, programs and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." Title II's implementing regulations defined the most integrated setting as one that, "enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible." Consistent with Section 504 of the Rehabilitation Act of 1973, the intent is to prohibit discrimination against people with disabilities, in this case in the form of unnecessary segregation in institutions or other settings considered to be segregated. In 2009, when President Obama announced his "Year of Community Living," marking the 10th anniversary of *Olmstead*, the U.S. Department of Justice (DOJ) began stepping up its efforts to enforce the rights of people with disabilities to live in integrated community settings under the ADA and *Olmstead*.

In 2011, the DOJ released guidance⁸ which defined integrated settings as "those that provide individuals with disabilities opportunities to live, work and receive services in the greater community, like individuals without disabilities." Consistent with the PSH model defined in SAMHSA's Evidence-Based Practices (EBP) Kit⁹ and with research on Housing First models of PSH¹⁰, the guidance went on to state that "evidence-based practices that provide scattered-site housing with supportive services are examples of integrated settings." The guidance also distinguished integrated settings from those considered as segregated, such as those that "have qualities of an institutional nature" and include "...congregate settings populated exclusively or primarily with individuals with disabilities... characterized by regimentation in daily activities, lack of privacy or autonomy, policies limiting visitors or limits on individuals' ability to engage freely in community activities and to manage their own activities of daily living..."

Since then, DOJ and state Protection and Advocacy (P&A) agencies have filed at least two dozen suits against states for ADA/*Olmstead* violations, with

DOJ Guidance on Integrated vs. Segregated Settings	
Integrated Settings...	Segregated Settings ...
<ul style="list-style-type: none"> ✓ Provide opportunities to live, work and receive services in the greater community ✓ Include evidence-based practices that provide scattered-site housing with supportive services 	<ul style="list-style-type: none"> ✓ Have qualities of an institutional nature ✓ Include congregate settings populated exclusively or primarily with people with disabilities ✓ Place limits on individuals' ability to engage freely in the community and to manage activities of daily living

⁸See: www.ada.gov/olmstead/g&a_olmstead.htm

⁹ The SAMHSA PSH EBP Kit measures PSH integration according to the extent to which tenants' housing units are scattered throughout the community vs. clustered with housing units occupied by other people with disabilities. The Kit states that ideally, tenants live in housing units typical of the community without clustering people with disabilities, but acknowledges the existence of integrated single-site PSH models.

¹⁰ Gilmer, T. P., Stefancic, A., Sklar, M., Tsemberis, S. (2013). Development and validation of a Housing First fidelity survey. *Psychiatric Services*, 64(9), 911–914; Gilmer, at al. (2014). Fidelity to the Housing First model and effectiveness of permanent supported housing programs in California. *Psychiatric Services* 65(11):1311-1317.

investigations underway in several others. The ensuing Settlement Agreements with states are aimed at remedying the unnecessary segregation of people with MI who reside in or who are at serious risk of entering institutions like state psychiatric hospitals, nursing facilities or other segregated settings such as large board and care homes. Implementation of the Agreements has required considerable expansion of PSH, along with other services that support successful community tenure such as Assertive Community Treatment (ACT), crisis services, peer support, intensive case management and supported employment. It has also necessitated major systems change efforts within states to finance and implement this expanded housing and services capacity. Further, most Agreements contain provisions that class members be given “informed choice”¹¹ of housing and services and recent DOJ Settlement Agreements have required that new integrated PSH housing options be primarily non-disability specific housing, with some also placing limits on the proportion of tenants with disabilities known to the state as a proxy for meeting the integration mandate.

Enforcement of the ADA and *Olmstead* has had an impact on people with MI including individuals with co-occurring SUD. People with primary SUD have not been the focus of these efforts, largely because SUD is not recognized as a disability by the Social Security Administration. Nevertheless, many of the community integration principles in the ADA and *Olmstead* are highly relevant for people with SUD who are in recovery.

Affordable Housing Policy and Programs

Successful implementation of *Olmstead* requires better leveraging of federal affordable housing resources that can provide and sustain integrated PSH opportunities. In 2013, the U.S. Department of Housing and Urban Development (HUD) released guidance acknowledging that, particularly in communities which had largely relied on institutional settings and/or housing occupied either in part or solely by people with disabilities, *Olmstead* accelerated the need to create additional PSH opportunities for people with disabilities in integrated settings. Methods encouraged by HUD to achieve this included the use of scattered-site apartments, tenant-based rental assistance in integrated housing developments and apartments scattered within public and multifamily housing developments. The guidance encouraged public housing agencies (PHAs) and other HUD-assisted housing providers to work within their communities to provide these types of integrated PSH opportunities.

HUD has since made a concerted effort, working in partnership with the U.S. Department of Health and Human Services (HHS) and with HHS Centers for Medicare and Medicaid Services (CMS) to direct more resources toward the expansion of integrated PSH options for low-income people with disabilities. The Section 811 Project Rental Assistance (PRA) program, authorized by the Frank Melville Supportive Housing Investment Act of 2010,¹² requires that the allocation of Section 811 resources by state housing agencies be leveraged with mainstream affordable housing resources such as Low Income Housing Tax Credits and targeted toward new housing developments where no more than 25 percent of the units are dedicated to qualified people with disabilities. The Section 811 PRA program also requires that state housing agencies formally partner with state Medicaid and other health and human

¹¹ Housing remedies under DOJ Settlements intend to ensure that people are given a meaningful choice to live in the most integrated setting, which is presumed by DOJ to be scattered-site housing. Settlement language typically states however that people may choose to live in other types of housing that may be available in their communities.

¹² See http://811resourcecenter.tacinc.org/media/775/tac_summary_811_programreforms.pdf for a summary of Melville Act reforms to HUD's Section 811 Program.

service agencies (e.g., state mental health authorities) to ensure outreach and referrals to PSH units and the availability of community-based services for tenants. Twenty-eight states and the District of Columbia have now received 811 PRA program awards. While HUD does not consider primary SUD a qualifying disability for the Section 811 PRA program, individuals with SUD do qualify on the basis of income for other mainstream affordable housing resources utilized by states to create integrated PSH, such as in Low Income Housing Tax Credit projects that also leverage Project-Based Section 8, for example.

This type of approach to large-scale development of integrated PSH units has been created in states such as Georgia, Illinois, Louisiana, North Carolina and Pennsylvania over the past several years, and is well-aligned with new National Housing Trust Fund resources that will be allocated to states beginning in 2016 for the production, rehabilitation and operation of affordable rental housing options for extremely low income households. In accordance with shifts in federal affordable housing policy and funding priorities, many states and localities have similarly moved toward financing more integrated housing approaches with their state/local affordable housing resources, potentially impacting many community behavioral health organizations who have historically relied on these resources (e.g., capital funds) for owner-operated housing and service programs.

Medicaid is the most cost-effective source of financing to states for the services that individuals with behavioral health disorders need to succeed in housing.

Other federal housing policies, including HUD's move to preserve more of its homeless Continuum of Care (CoC) funding for housing-specific costs and maximize the use of mainstream resources to pay for services and the recent Notice¹³ encouraging the prioritization of chronically homeless individuals to move into CoC-funded PSH, have meant that many CoC-funded PSH providers must leverage other sources of funding to sustain and expand services and, in some cases, offer more robust service packages to effectively serve chronically homeless people with serious health and behavioral health needs. In addition, HUD's most recent CoC funding competition resulted in bonus awards to new PSH projects in 25 communities¹⁴ based in part on their ability to leverage Medicaid resources to finance services like case management, tenancy supports, behavioral health and other services that support housing stability, either by directly billing Medicaid or through formal partnerships with one or more Medicaid billable providers like Federally Qualified Health Centers (FQHCs).

These policies, and the expansion of integrated PSH opportunities as a result of *Olmstead*, have driven home the necessity to better leverage Medicaid and other mainstream service system resources to finance and deliver the supportive services component of PSH for people with complex behavioral health needs relative to the expansion of related housing opportunities.

¹³ HUD Notice CPD-14-012 Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing. Available online at: <http://portal.hud.gov/hudportal/documents/huddoc?id=14-12cpdn.pdf>

¹⁴ FY2014 Homeless Assistance Projects Receiving Bonus Awards. Available online at: www.endhomelessness.org/library/entry/25-communities

Medicaid Services Financing

The core components of PSH include affordable housing and a broad array of medical and non-medical services which are made available to a person to meet a broad range of needs. Medicaid is statutorily prohibited from paying for housing in the form of room and board, rental assistance or non-medical services and it pays for services attached to a person not a program. It is also the most cost-effective source of financing to states for the types of community-based services and supports that people with behavioral health disorders need in order to be successful in PSH because it leverages federal financial participation. Systems change efforts aimed at maximizing the use of Medicaid to finance and deliver these services and preserving and redirecting limited non-Medicaid resources to cover the cost of what Medicaid cannot are critical to ensure the necessary services and supports people need to move into and maintain PSH are in place. Thus, it is critical to understand the role that funding sources have in making PSH work and why partnerships between state housing, Medicaid and behavioral health agencies, along with community and provider-level approaches to tapping into mainstream service system funding, are ever more necessary.

Recent CMS guidance¹⁵ outlines how states can incorporate into a Medicaid benefit design certain defined housing-related activities and services which support community integration among people with disabilities. As states maximize Medicaid to pay for housing-related services in PSH settings, agencies that have historically relied on state or local funds will need to carefully consider the business and provider requirements to become Medicaid certified or work with providers who are or will become certified. In some situations, providers may be expected to make this shift to generate Medicaid revenue to pay for many services that were previously reimbursed by grants or contracts. In addition, providers will need to develop strategies for expediting and maintaining Medicaid eligibility and enrollment for the individuals they serve.

Shifts in federal affordable housing policy and funding has led many states to finance integrated housing like PSH with their state/local housing resources, impacting community behavioral health organizations who have relied on these resources for owner-operated housing and service programs.

Olmstead settlements targeting people with MI have influenced how Medicaid home and community-based services (HCBS) and other resources are or will be used to reimburse the types of services that support community integration for people with MI and co-occurring SUD in affected states. Provisions in the ACA also expand opportunities for states to utilize HCBS to provide flexible, person-centered services consistent with the integrated PSH approach. Perhaps most importantly, the ACA provides opportunities for greater services coverage and access for people with MI and/or SUD to have both their behavioral health and primary health care needs met, while also allowing states to leverage a greater share of federal Medicaid dollars and potentially free up behavioral health system resources spent on costly institutional care to expand access to quality housing, services and supports that promote community integration and recovery.

The option provided under the ACA for states to expand Medicaid coverage for people with incomes at or below 138 percent of Federal Poverty Level has had a direct impact on making significantly more

¹⁵ CMS Informational Bulletin on Coverage of Housing-Related Activities and Services for Individuals with Disabilities. Available online at: www.medicaid.gov/federal-policy-guidance/downloads/CIB-06-26-2015.pdf.

people with MI and SUD eligible for coverage. Most states that have expanded Medicaid under the ACA have offered coverage that is aligned with traditional state Medicaid coverage for adults. States not offering services through the traditional Medicaid plan must offer Alternative Benefit Plans (ABPs) that contain access to 10 essential health benefits, including mental health and SUD services, as well as prescription drugs, rehabilitative and habilitative services and other important health-related services. ABPs also must cover treatment for mental health and SUD at parity with physical health benefits, although traditional Medicaid coverage must be offered to consumers who are designated as “medically frail,”¹⁶ including those with serious mental illness and SUD. For people with MI and/or SUD this means better access to services to meet behavioral health and health care needs alike. In particular, Medicaid coverage of the ABPs has resulted in dramatic expansion of SUD treatment benefits. Many states opting not to expand Medicaid under the ACA have implemented similar coverage expansions. As more individuals access SUD treatment, the need for additional housing options following treatment to support individuals with the long-term recovery process becomes even more critical.

At the federal level, CMS has supported provisions in the ACA to reduce care in institutional settings and expand home and community-based services (HCBS) through long-term care rebalancing initiatives like the Balancing Incentives Program (BIP) and expansion of its Money Follows the Person (MFP) demonstration program, as well as new and improved options for the delivery of Medicaid HCBS. Modifications to the 1915(i) HCBS State Plan Option now allows states to serve individuals at a higher income threshold, target services to specific populations and make more services available. A new state plan option is also now available through 1915(k) Community First Choice (CFC) to provide home and community-based attendant services. Community behavioral health organizations should be aware of initial and reoccurring eligibility screening requirements, specific populations covered and specific services covered by a waiver to determine its applicability to housing-related services and supports.

In March 2014, CMS released a final rule¹⁷ establishing person-centered planning requirements for individuals receiving HCBS, as well as requirements for the settings in which Medicaid HCBS can be delivered. The final rule defined settings in which HCBS were eligible for reimbursement consistent with the community integration mandate under the ACA and *Olmstead*-related DOJ guidance and the PSH principles defined in SAMHSA’s EBP Kit¹⁸, as those that are integrated in and support full access to the community, offer a choice of options, ensure rights of privacy and autonomy/independence in making life choices and facilitate choice regarding services and who provides them. It further requires that settings which are provider owned or operated provide individuals with a lease or similar legally enforceable agreement, privacy in their unit, choice of roommates and control over things like decorating, one’s own daily schedule, and access to food and visitors. The rule also defines settings

¹⁶ Promoting Effective Identification of Medically Frail Individuals Under Medicaid Expansion. Available online at: www.thenationalcouncil.org/wp-content/uploads/2015/07/15_Medically-Frail-Issue-Brief-v4.pdf.

¹⁷ The final rule establishes person-centered planning requirements for 1915(c) and 1915(i) authorities (person-centered planning requirements for 1915(k) are established outside of this rule), as well as settings requirements for 1915(c), 1915(i) and 1915(k) authorities and 1115 demonstrations. See: www.federalregister.gov/articles/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider.

¹⁸ For an analysis of the HCBS Settings Rule compared with *Olmstead* and PSH Principles, see: www.tacinc.org/media/46123/HCBS_Olmstead_PSH%20Comparison%20Table_FINAL%208%2025%202014.pdf.

presumed to have institutional qualities that are therefore not in compliance with the HCBS setting requirement.

As a result, states that are or that plan to offer Medicaid HCBS linked to community-based housing settings must assess these settings for compliance with the new requirements, in addition to revisiting policies and regulations, service definitions and standards, provider qualifications, and quality and outcome/performance measures to ensure the principles articulated in the final rule are incorporated into the system overall.¹⁹ Ultimately, systems may need to look toward developing more capacity within settings that meet these requirements in the event existing settings are unable to comply and the individuals served in them must be transitioned to other options.

Eligible Settings for Medicaid HCBS must:

- ✓ Be integrated in and support full access to the community
- ✓ Offer a choice of options
- ✓ Ensure rights of privacy and autonomy/independence in making life choices
- ✓ Facilitate choice regarding services and who provides them
- ✓ *(If provider owned or operated)* provide individuals with:
 - a lease or similar legally enforceable agreement
 - privacy in their unit
 - choice of roommates

More recently, in July 2015, CMS issued a State Medicaid Director letter²⁰ informing states of a new opportunity to apply for Section 1115 Demonstration Waivers to test Medicaid coverage of a full SUD treatment service array in the context of comprehensive SUD system transformation. Among CMS' expectations for states applying for this opportunity is a comprehensive continuum of care that includes long-term recovery supports such as housing and that addresses the community integration requirements set forth in the new HCBS settings rule as part of a transformed SUD service delivery system. For SUD systems, this presents an opportunity to incorporate PSH as a long-term rehabilitation and recovery support model as a complement to residential treatment and Recovery Housing options.

Implications for Behavioral Health Authorities and Providers

Behavioral Health Authorities

Behavioral health authorities are unique in their historical approaches to addressing the housing needs of individuals with behavioral health needs and in responding to recent shifts in policy and funding which impact the types of housing and service models being offered in communities across the country. Alignment of the various policy, legal and financing issues is a catalyst for states to modify financing and service delivery approaches to achieve the goals of community integration and Medicaid cost containment and rebalancing. Consequently, behavioral health authorities are challenged to examine their existing residential housing and services approaches and include additional options, such as PSH, that are cost-effective and aligned with state's obligations under the ADA and *Olmstead*.

This requires that these systems take stock of the capacity that exists among each type of residential housing and service option within their system and assess the alignment of each with DOJ *Olmstead*

¹⁹ To view state transition plans to comply with the HCBS rule, see: www.medicare.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/statewide-transition-plans.html.

²⁰ See: <http://medicaid.gov/federal-policy-guidance/downloads/smd15003.pdf>.

guidance regarding what constitutes an integrated vs. segregated setting²¹, Medicaid requirements, and best practices in order to identify the right mix that should be available in the system. It also means behavioral health authorities should take a closer look at how residential options are being utilized. Who is accessing each option? How is eligibility and access determined (i.e., primarily based on clinical judgment of need, on consumer preference/choice or other factors)? What are the preferences of people coming into and being served by the system? Assessing these types of factors may lead a local behavioral health authority, for example, to look at reprogramming some existing residential treatment capacity, preserving some of that capacity to meet assessed needs within the system, while also freeing up some resources to support and/or help people transition to more integrated PSH options. Within SUD treatment systems, while many individuals will continue to need and benefit from residential treatment, PSH options may be expanded as a rehabilitation, recovery and supports model that some may desire and benefit from, and given access to a broader array of services coverage for SUD, many of their PSH-related services may be reimbursable by Medicaid. Others may need or want PSH to support them in their recovery once they graduate and/or step down from residential treatment. In either case, the need for clear links to and movement toward PSH as an option for those who want and need it becomes ever clearer.

For behavioral health authorities and agencies, expanding PSH options to meet individual needs and preferences not only requires forging or expanding partnerships with state and local housing agencies to tap into mainstream affordable housing resources, it also means rethinking and better targeting of limited behavioral health resources to ensure a range of housing options which includes integrated housing models. As system leaders begin to reassess their available housing and service options against what is needed in the system based on the assessed needs and preferences of those served, they must often reconsider who could live in a community integrated housing setting like PSH with the right kinds of services and supports. This inevitably means assessing the system's capacity to pay for and of providers to effectively deliver community-based services and supports in integrated PSH settings. As this occurs, state Medicaid and behavioral health agencies are working together to implement service delivery models, payment strategies and quality/performance measures that support and incentivize providers to move people with complex behavioral health needs toward and assist them to achieve stable housing and recovery in these types of settings.

Community Behavioral Health Organizations

Community behavioral health organizations continually need to adapt to a changing environment, inclusive of new housing models that can be effective and an increasing reliance on Medicaid-funded services. MI and SUD treatment system providers have various roles in relation to operating housing and services. Traditionally, many providers purchased or developed group homes, residential treatment facilities or "single purpose" (e.g., serving one disability or other eligible target population) PSH buildings to meet housing demand for those they served because mainstream affordable housing did not exist or was not accessible. Funding was typically cobbled together with various capital sources (e.g., state general funds, bond funds, federal resources, etc.) and providers were often left without sufficient operating resources, making ongoing repair, maintenance and other operating issues an annual fiscal challenge. Other providers have chosen to partner with affordable housing developers, owners/landlords or other housing entities such as local homeless Continuums of Care (CoC),

²¹ See www.ada.gov/olmstead/q&a_olmstead.htm.

city/county housing departments and Public Housing Agencies (PHAs) to provide housing resources so the service provider can focus on delivering services to individuals accessing affordable housing through these entities.

Changes in state and local behavioral health system policies that support the creation of more integrated PSH options means providers may have to adapt to a system that partners with and relies more on the affordable housing community to fund and develop housing, while services are delivered independent of or separate from housing in a flexible, individualized manner. This also means a fundamental shift from providers receiving program-based funding for the operation of bundled housing and service programs, to being reimbursed for mobile, person-centered services delivered to individuals. Thus, providers who also own and/or operate housing will need to consider how this policy context impacts their current housing and service delivery model and use it to inform decisions about their future role as a developer, housing operator and service provider.

As states seek to leverage Medicaid to finance housing-related services in PSH, behavioral health authorities will likely require community behavioral health organizations that are providing housing-related services and supports to meet the requirements and bill Medicaid for eligible services. Taking advantage of Medicaid to finance and deliver these services ultimately requires changes in business thinking and planning for many providers who may have been operating primarily with HUD or state behavioral health system dollars and are not currently billing Medicaid. These will need to assess their organizational readiness and develop a business plan to ensure the financial resources, organizational infrastructure and management capacity to support becoming a Medicaid billable provider. System leaders can support organizations by assisting with these types of provider self-assessment and planning processes, assessing staffing needs and the ability to meet certification, credentialing and/or accreditation requirements and working with managed care. Community behavioral health organizations may also need assistance determining what their workforce development needs are in order to develop the skills and expertise necessary to implement best practice service models that support individuals in integrated PSH settings, along with technical assistance and training to meet those needs.

As states are obligated to move their behavioral health authorities toward supporting more integrated housing and service models, non-Medicaid funding sources will continue to be essential to cover provider costs and ensure the full spectrum of services people need to succeed in housing. As Medicaid increasingly factors into the financing of services that can be provided in PSH settings, providers will need to diversify their financing and adapt to doing business in this new environment. In a Medicaid environment, especially a managed care environment, providers will assume more risk having to provide services that are authorized and reimbursed at predefined or capped rates to budget revenues from multiple sources (i.e., Medicaid, state grants and contracts) and to minimize expenses. As providers assume more financial risk for providing services in community integrated settings like PSH, behavioral health system leaders must acknowledge that fluctuations in revenue will impact providers. System leaders can support providers through this transition, for example, by setting adequate rates for Medicaid reimbursable services, lining up other federal and state/local funding resources to fill gaps in housing-related services coverage and working to encourage flexibility within managed care arrangements.

Opportunities within Medicaid to Finance and Deliver Housing-Related Services

Historical Financing and Delivery of Housing-Related Services in Supportive Housing

Exploring opportunities within Medicaid to finance and deliver housing-related services in integrated community settings like PSH is best done after first considering the history of financing and delivering these types of services. Housing-related services have historically been financially supported with program-based funding through contracts administered by federal, state and local funders. In this context, residential services have typically been funded for specific populations or sub-populations in a “program-based” or “supervision-based” model with funding organized to cover program costs rather than for individually tailored services. This support has often continued to be provided based on historical funding arrangements without the benefit or requirement that services be provided consistent with newer, best practice service modalities that assist people with behavioral health disorders get and keep housing.

Housing-related services include a range of flexible services and supports that assist individuals to transition to and maintain housing in community integrated settings like PSH

In a Medicaid environment, traditional grant-funded, program-based models that rely on a singular funding source will need to adapt to reimbursement for services based on individual needs in a Medicaid environment. Depending on the payer arrangement in systems, this may be on a fee for service basis or, increasingly, another pay for performance, bundled or case rate mechanism. Systems will need to ensure that Medicaid eligible services reflect legitimate costs and that non-Medicaid eligible services are reimbursed by other funding sources, such as state general funds.

Approaches to Covering Housing-Related Services and Supports

Exploring Medicaid opportunities to finance and deliver services in supportive housing also requires some consideration of the best coverage approaches for the types of housing-related services and supports people need to succeed in PSH settings. While there is no specific Medicaid-financed “supportive housing service” covered under any of the Medicaid authorities, many of the key service activities and interventions necessary for individuals to get and keep housing may be covered by Medicaid. In June 2015, CMS released an Informational Bulletin²² that, in part, describes the housing-related activities and services Medicaid can assist in covering that have proven to be cost-effective and to facilitate community integration among people with disabilities. These include services that provide direct support to assist individuals prepare for and transition to housing, as well as successfully maintain housing after move-in. These activities can be embedded in part or whole into three broad categories of services which may be included in an individual's person-centered care plan and are already covered by Medicaid. For many persons with complex behavioral health conditions, embedding housing-related services into these other essential services ensures access to the broader spectrum of services necessary to an individual's success in PSH.

The first category of services includes existing best practice community-based services that are typically long-term in nature and designed to assist people with serious and long-term disabilities

²² www.medicaid.gov/federal-policy-guidance/downloads/CIB-06-26-2015.pdf.

live successfully in the community. Housing-related interventions may be embedded into these existing and routinely covered services—such as intensive outpatient programs (IOP), Assertive Community Treatment (ACT), community support, psychiatric rehabilitation and direct services case management—under one or more of the Medicaid authorities, typically within categorical and coverage limits. This approach views housing as an integral rather than non-essential part of treatment and recovery, enhancing a person's overall well-being and community tenure. An example would be a case manager or housing specialist on an ACT team assisting an individual to making a housing choice or negotiate with a landlord.

The second category of services within which key housing-related services may be imbedded includes existing targeted support and treatment interventions that enable people to move into and live in their own home. This may include but not be limited to personal care, home health, specialized care for chronic health conditions, supported employment, Critical Time Intervention (CTI) or other targeted care coordination interventions, respite and crisis prevention and stabilization. These services are reimbursed by Medicaid as related to a person's pre-existing or emerging chronic health condition, a cognitive impairment or some other type of disability or condition that requires very specific attention for a person to live in their own home. If not for this specific type of in-home intervention, a person needing daily nursing assistance, for example, would have to live in a relative's home or a nursing home rather than their own home.

The third category of services includes existing ongoing supports received from community or housing support staff, peers, AA/NA or other recovery support groups, wellness and other community-based organizations such as neighborhood, wellness or drop-in centers, etc. These ongoing supports are essential to ensuring that individuals living in integrated community settings like PSH have support within their community as well as options for how they spend leisure time. While many of these supports are available, not all are covered by Medicaid. Some of these supports are available at little or no cost to persons living in the community, while others will need to be paid for by other non-Medicaid resources.

Analyzing Housing-Related Service Arrangements

Considering the approaches to covering housing-related services and supports discussed above, and further defining the specific activities and interventions that support individuals to access and maintain housing allows behavioral health authority leadership and community behavioral health organizations to begin to compare these with coverable Medicaid interventions and services and identify coverage gaps and options for filling them. Please view the table on page 4 to view housing-related service arrangements and potential reimbursement strategies.

Review and Comparative Analysis of Medicaid Authorities/Demonstrations

Table 2 lists selected specific Medicaid authorities/demonstrations that can be used to finance housing-related services. While each option has federal or state requirements that should be reviewed in more detail than provided in this paper, this overview builds on the CMS Informational Bulletin and sets the stage for the next step in analyzing the potential benefits and challenges of using Medicaid resources

as a health benefit and a source of financial support for some of the necessary services people with BH disorders need to succeed in community integrated housing settings like PSH.

Table 2: Medicaid Options for Coverage of Housing-Related Services

Medicaid Option	Comments
1905 (a)	Includes a broad range of mandatory (outpatient services, FQHCs, etc.) and widely used optional services (Rehabilitation Option).
1915(b) Waivers	Historically used by states to allow managed care arrangements for persons with behavioral health conditions. Requires cost neutrality, may restrict choices, limits provider pool but also requires sufficient network and also offer opportunities for using savings (b)3 to provide additional services.
1915(i) SPA	State Plan Amendment (SPA) allows states to cover Home and Community Based Services with some flexibility, including many of the essential, flexible housing-related services. Services must be statewide and eligibility tied to persons with specifically defined health conditions and functional needs rather than being tied to a specific diagnostic grouping.
Money Follows the Person (MFP)	MFP was established to help states rebalance their long-term care expenditures between institutions and community programs. MFP is limited to people with >30 days institutional care—not applicable to homeless or at-risk populations. MFP services are time-limited and require 1915(c) or other resources for ongoing community services for MFP participants.
Balancing Incentives Program (BIP)	The BIP provides new ways to serve more people in home and community-based settings, consistent with the integration mandate of the Americans with Disabilities Act (ADA), and as required by the <i>Olmstead</i> decision. The BIP was created by the Affordable Care Act (ACA) of 2010 (Section 10202).
1915(c) Waivers	Services similar to those in the 1915(i) targeted to people who are institutionalized or at risk of institutionalization, with priority for state hospital patients—must meet Nursing Facility level of care.
1915(b) and (c) Combined	Combines benefits of both waivers and enables states to manage their (c) services for persons with disabilities.
1115 Research and Demonstration Waiver	Could be used to demonstrate combination of health integration, care coordination and supportive housing services for the target population.
Medicaid managed care authorities (e.g., 1932(a))	Voluntary enrollment; need to access state plan services; requires RFP for managed care entity to manage
Health Homes Waiver (2703)	Health homes include both a care coordination and enhanced services for individuals with chronic health conditions. States implementing health homes will get an initial enhanced Medicaid match (90 percent) for eight quarters, population/ condition specific, with a variety of lead agency and payment models
Targeted Case Management (1905[a])	TCM is widely used broker/linkage service. It does not include all necessary services—very limited direct service functions.
Health Care Innovation Models	Grants to assist states with innovations in payment and treatment models and in primary care transformation and best practices the state is adopting in response to ACA opportunities.
Non-Medicaid Option	Comments
Sources of revenue used to pay for non-Medicaid eligible services may include state general fund appropriations, county or local funds or other sources for housing-related services	Medicaid is unlikely to pay for all housing-related services and should not be used as a state strategy to eliminate the need for or use of state general funds or other sources.

Comparing and contrasting the various Medicaid Authorities and Demonstrations and their fit for a particular system’s needs in terms of coverage of housing-related services necessitates a multi-step process which involves:

1. Identifying the key objective for utilizing Medicaid to cover housing-related services. Is it mainly to expand the resource base or maximize federal financial participation? Is it also to assure individuals have access to the coverable services they need to get housing and remain successfully housed? Is it to assist people to exit institutions, shift the system's resources from more costly congregate care to more integrated supportive services and housing including meeting an *Olmstead* obligation for integration and choice? Or, is it some or all of the above? Any analysis should be tailored to determining if that objective(s) can be met.
2. Engaging state Medicaid and behavioral health leadership, your state or local provider trade group and local health/housing planners, philanthropy, managed care organizations and key stakeholders to determine their interest in the above objective(s), as well as their interest in participating in an analysis. In doing this, learning, gauging and framing the issues from the perspective of your potential partners is important.
3. Conducting a penetration analysis by population, health conditions and program, projected enrollment challenges including current or potential caps.
4. Analyzing options by type of authority and program for both Medicaid and state funding based on the following:
 - Medicaid options already being exercised within a state to see what can be done with no or minimal changes in order to cover housing-related services;
 - Eligibility criteria for services—diagnostic, ability and limitations of targeting persons such high users, health and/or functional needs;
 - Medical necessity and categorical service criteria including criteria for changes in levels, type and/or intensity of services as a result of a prior or concurrent review for individuals when long-term housing stability is critical to a person's health outcomes and included as a treatment goal;
 - Allowable services and supports including on and off site restrictions and opportunities;
 - Licensing, credentialing requirements and/or certification;
 - Transitional requirements and challenges (persons exiting institutions or jail/prison);
 - Professional requirements and provider availability;
 - Other restrictions or benefits based on particular authorities or programs including cost neutrality, demonstration requirements, provider choice and limitations, state wideness, etc.; and
 - Potential and projections for costs that can be impacted and allowable and potential use of savings.
5. Examining rates and payment options.
6. Quantifying needed upfront investment costs and time required to shift from program funding to Medicaid reimbursement.

7. Determining interest from other health care providers and managed care organizations to enter into a partnership or utilize supportive housing as part of their business plan, their care coordination teams, navigator projects, high utilizer programs, co-location or shared service arrangements, networks, activities directed at cost restructuring, quality improvement and reduction strategies.
8. Analyzing transition and ongoing revenues/costs based on productivity and break even analysis, and identifying reimbursable and non-reimbursable tasks at the staff and program level.
9. Analyzing costs and benefits of record keeping, reporting and billing systems and choices for intermediary administrative and billing arrangements, including determining what requirements may be in place for tracking and reporting housing-related activities.
10. Analyzing person-centered planning, service (medical) necessity and service delivery requirements and housing-related "best practices" that can be adopted as part of an existing Medicaid supported program.
11. Analyzing the potential for centralizing selected housing activities to create efficiencies in the system and enable local behavioral health service providers to take advantage of them. For example, outreach/marketing with housing providers (e.g., landlords, developers, PHAs) to create centralized access to a "pool" of housing units, incentivizing housing providers by sending them pre-screened applicants eligible for their housing and/or subsidy program. This will keep them engaged in continuing to work with BH providers and consumers. Tracking housing access and outcomes to support system improvement and future expansion of housing and services can be centralized through a designated entity like a BH system "housing clearinghouse."

System Strategies to Support Provider Implementation

Both housing and community behavioral health organizations are being asked to adapt to significant changes in the health care financing landscape. At the same time, the aforementioned changes in housing and services policies resulting from the enforcement of federal community integration laws and long-term care reform has hospitals, MCOs and state Medicaid agencies increasingly promoting PSH strategies.

The strategies for considering Medicaid in the prior section focus on framing the possibilities and challenges. Information gleaned from the suggested analyses provide the basis for provider-level implementation. For example, aligning staffing with current or proposed staff qualifications, adopting service or recovery planning, record keeping and reporting may require shifts in program operation. It is almost always preferable to learn as much as possible about current and proposed state Medicaid and other funding plans. Strategies for behavioral health system leaders to consider for supporting provider implementation of Medicaid-financed services tied to integrated community housing settings like PSH are described below.

Educate and give MCOs responsibility for housing-related services contracting. Behavioral health authorities can play a role in educating managed care entities about the impact of stable housing in terms of costs and improved outcomes for people with behavioral health needs and ensure that state contracts with MCOs include the expectation of covering housing-related services. In managed

behavioral health authorities, Medicaid reimbursable housing-related services should be incorporated into provider contracts and tailored to meet the needs of the targeted populations, "high utilizers" and/or *Olmstead* class members by, for example, requesting supplemental or reinvestment service arrangements. It also may more easily enable service providers to be paid using some of the newer payment mechanisms or to receive incentive payments when a model like PSH is utilized to reduce costs. One example is payment for "in-reach" services like warm handoffs, discharge or transition planning which may or may not be covered by Medicaid when an individual is still an inpatient, in residential treatment or doesn't meet the length of stay threshold for MFP. The second is to expand the opportunities for peer support staff to assist persons to get and keep their housing. One challenge to this overall strategy is that most MCOs have limited operational responsibilities contracting for services in PSH settings and would need to develop provider networks with expertise to take on these responsibilities. Another is that behavioral health system leaders need to add these responsibilities to state managed care solicitations and contracts, explicitly addressing the coverage of housing-related services as a contract requirement. Third, without clear expectations and intentional activities to avoid poor housing outcomes such as evictions, efforts to successfully serve individuals in PSH settings could be jeopardized.

Establish specialized care coordination functions for housing-related activities for MCOs. In tandem with the previous recommendation, this can be done in much the same way MCOs manage high risk youth services or high utilizers of inpatient care. This may even include modifications of service authorization and clinical care review functions that may also be carried out by other organizations in tandem with MCOs. In some states, these functions are implemented by cross-agency community care teams or newly organized hospital-led teams. Today, more hospitals are financing community alternatives or providing staff to lead or coordinate these activities.

State/local authority and provider-level business planning. The intent of business planning is for a provider (or group of providers) to better understand and set their course for adapting to already implemented or proposed changes resulting from state-level responses to the ACA or other health care system reform efforts, *Olmstead* or state/county government fiscal problems. Business planning to take advantage of Medicaid to fund housing-related services could be done as part of, or consistent with, these overall efforts to reduce redundancies, take advantage of an already existing planning process and reduce the potential that housing is an afterthought, thus making it less likely for the agency to succeed in their housing-related endeavors or responsibilities.

There are some unique tasks associated with business planning for housing-related activities, but overall business planning including cost and revenue analysis is done on the same platform as an agency would have used for overall agency planning. However, several unique business planning activities apply. One is conducting a time study that includes identifying and assessing time committed to essential supportive housing functions that are not coverable Medicaid interventions or coverable with another funding source, determining if these activities are covered as part of an agency's administrative function and costs included in the rate for services.

Another is determining potential differences in the level of acuity, expected interventions and challenges that serving any new population in PSH may present and related changes that must be

made to services and service delivery. For example "housing first" expectations may be quite different for persons with co-occurring disorders than for persons who have exited residential programs. Persons exiting adult or personal care homes or institutions directly into PSH may require more or different levels of care. Another consideration is how best to retain the requirement that PSH services be voluntary when serving persons who have higher levels of acuity, significant self-care needs or high needs for relapse prevention. Likewise, it will be important to determine what service approaches are successful and critical to serving persons with legal system involvement that places conditions or requirements on their receipt of services.

Quality Improvement/performance measurement activities and workforce development.

Behavioral health system leaders can enhance the success of providers delivering housing-related services by supporting specific performance measurement and quality improvement activities as well as targeted training/coaching programs and workforce strategies. Some states are beginning to offer ongoing housing-related services training and coaching activities. Long-term coaching is especially useful as service providers begin to serve persons with higher acuity and more complex needs in PSH settings. Community care teams and care coordinators can be good sources of information for establishing training and coaching priorities and their activities are good venues for carrying out case consultation. Peer certification or provider certification programs are also ideal workforce strategies.

At the system level, *Olmstead* settlement agreements are not only setting targets for PSH expansion, several include quality improvement and performance requirements. Parties to Settlement Agreements should give special attention to shaping these agreements to enhance overall system performance including success of PSH initiatives. Over time, this focus enables a state to affirmatively meet *Olmstead* and ADA Title II requirements which is the desired result. HUD's new Section 811 PRA program requires states to focus on performance and includes reporting requirements that provide the opportunity to measure performance across states participating in the program. Opportunity exists for performance and quality measures in provider and managed care contracts to mirror those in Settlement Agreements and the 811 PRA program, examining issues such as length of time between identification of housing needs/preferences and move-in to housing, length of stay in housing, access to health/behavioral health services and recovery supports, employment, etc. and reasons for exiting housing. The result could be a richer analysis of the successes and challenges of delivering housing-related services in community integrated housing settings like PSH, giving systems and providers an even better understanding of the expectations and potential outcomes of these services.

State Implementation Case Studies

New Jersey Division of Mental Health and Addiction Services (DMHAS)

As a result of an *Olmstead* Settlement Agreement, the New Jersey Division of Mental Health and Addiction Services (DMHAS) within the Department of Human Services (DHS) has implemented reform initiatives over the last decade within its public behavioral health system to move people out of state psychiatric hospitals who no longer need to be there and to prevent unnecessary hospitalization or homelessness. To comply with the Agreement, DMHAS ceased further development of congregate group home settings and began developing permanent supportive housing (PSH) options through the development of a state subsidy program.

Person-centered, flexible services were initially funded using state dollars and providers that were also a Medicaid Assertive Community Treatment (ACT) or targeted case management (TCM) provider could bill appropriate services. Concurrent to implementing the Agreement, the state submitted and had approved by CMS a State Plan Amendment to add a Community Support Services (CSS) to its Medicaid state plan using the Rehabilitation Services Option, which allows services to be provided in community settings, including a person's home or work environment, by a broader range of professionals, such as paraprofessionals and peers, with a focus on recovery-based illness management, crisis support, coordination and management and skill-building services necessary for everyday living. DMHAS is currently working on implementation of the CSS service which will allow, for the first time, providers to bill Medicaid for services to individuals living in PSH settings.

To launch the new Medicaid service, DMHAS needed to develop an appropriate rate structure, as well as state regulations for this service. DMHAS also launched a number of technical assistance (TA) opportunities to prepare providers for this change. This included a nine-month workforce training initiative for both direct care and supervisory level staff on the types of services to be provided (i.e., skill building, crisis, housing and tenant supports), consumer engagement, rehabilitation assessment and development of an Individualized Rehabilitation Plan and services documentation for billing purposes. As the state was launching a new service, it was also developing new methods to pay for service. Thus, to prepare providers to develop a new business model to provide and be reimbursed for the service, DMHAS also applied to SAMSHA to become a convener for BH Business and used the model to provide fiscal and budget TA to providers who applied and participated in a number of modules, including Strategic Planning, Third Party Billing practices and Business Operations.

Finally, in order to comply with CMS' new HCBS settings rule, DMHAS and providers began a process to separate housing from services. Due to the lack of affordable housing in the state, many community behavioral health organizations had developed housing options for the consumers they served using state resources, HUD programs and other resources for capital investments. As a result, many operated as both housing and service provider, limiting choice for consumers. In order to address this issue, DMHAS partnered with the New Jersey Housing and Mortgage Finance Agency (HMFA) to operate its state subsidy program. In July 2015, the HMFA began operating the Supportive Housing Connection (SHC) for this purpose. SHC functions as a "Clearinghouse," responsible for rent payment to landlords, eligibility verification, lease-up, unit inspections, tenant/landlord relations and establishing and maintaining a waiting list based on the state's priority populations. Prior to the shift of responsibility to the SHC, 45 community behavioral health organizations controlled the subsidy resources and paid landlords. At times, providers did not fully utilize their subsidy funds in a timely manner resulting in inefficient use of resources and fewer individuals getting housed. Thus, DMHAS is phasing provider agencies into using the SHC to limit the financial impact to them. Also, some of the housing-related duties providers previously performed, such as unit inspections, will not be billable as agencies begin to bill Medicaid for CSS, which is another reason to transfer these tasks to the SHC and allow providers to focus on supportive service delivery.

As a result of the state's strategy to expand PSH for individuals with mental illness, there are now nearly 5,800 people living in supportive housing and the state plans to continue using state funds and

savings achieved through leveraging Medicaid to pay for housing-related supports and activities which are not reimbursable by Medicaid.

Worth noting is that in addition to providing seed or capacity building funding to agencies to develop sober housing options, DMHAS has also developed PSH as an option for people with SUD. This includes a state-funded PSH program that utilizes a Housing First approach for individuals experiencing homelessness who are also addicted to opiates and need a low-demand approach in order to access safe, affordable housing and slowly engage in treatment and services. DMHAS expanded the program using Social Service Block Grant (SSBG) dollars the state received to assist with recovery efforts following Super Storm Sandy in 2012. DMHAS developed a subsidy program coupled with services for those living in storm impacted areas and, as a result, more than 100 individuals with SUD accessed and maintained PSH, with many decreasing their reliance on support services over time. As the time-limited SSBG funding ends, the state is using its own resources to continue the housing subsidy for those with demonstrated financial need. The state will also pursue other Medicaid options for the service dollars in light of the issuance of the recent “Dear State Medicaid Director” letter highlighting 1115 Waiver Demonstration programs as an option for states to serve those with SUD.

Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS)

The Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS) within the Department of Human Services (DHS) has been re-deploying state-funded residential and services resources for over a decade to develop more integrated, recovery-oriented housing opportunities for people with mental illness. This has been driven in part by *Olmstead* and the closure of state-operated facilities, as well as advocacy by county mental health departments which have repeatedly identified integrated housing opportunities as an urgent need among people with mental illness. About a decade ago, OMHSAS began working with selected counties to develop housing plans in partnership with local housing organizations and the Pennsylvania Housing Finance Agency (PHFA). PHFA requires affordable housing developers utilizing the Low Income Housing Tax Credit (LIHTC) program to target housing units for extremely low-income people with disabilities, including individuals who are homeless, and non-homeless households requiring supportive services including persons with mental, physical, sensory or developmental disabilities; persons with substance use disorders; persons diagnosed with HIV/AIDS and related diseases and other special populations. These units are accessible to OMHSAS priority consumers for supportive housing through locally established housing referral and service coordination entities called Local Lead Agencies. Since then, OMHSAS housing staff have expanded this effort statewide, working with other county mental health departments to develop and implement housing plans that create similar PSH opportunities for OMHSAS priority consumers.

While the PSH developed in partnership with PHFA through the LIHTC program is accessible to a cross-disability population, individuals with mental illness largely benefit from many of these and other supportive housing opportunities developed within the state due to availability of targeted reinvestment funds. Funding for behavioral health services in Pennsylvania is primarily through a 1915(b)(3) Managed Care Waiver, which supports the Health Choices Behavioral Health Program (HCBHP) overseen by OMHSAS. Under the HCBHP, county-based behavioral health managed care organizations (BHMCO), or the county itself, provide access to a range of mental health and substance use services delivered by community behavioral health organizations. Under its contracts with the counties, savings generated

can be used to develop additional services and supports in accordance with an OMHSAS approved reinvestment plan, providing counties a framework to effectively invest and utilize the “reinvestment funds” to develop supportive housing and services for people with mental illness. Reinvestment funds also in part serve to bridge the gap for providers as they transition to new models of delivering housing and services and for services reimbursement. Reinvestment funds can only be identified and used after the BHMCO or county meets its annual contract and risk and contingency requirements.

Four of the reinvestment strategies focus specifically on the provision of capital or operating/rental assistance to support the creation of PSH and include: 1) capital or equity investment in development projects, 2) project-based operating assistance to subsidize rents in multi-family housing, 3) short-term bridge rental assistance and 4) master leasing for consumers with criminal or poor tenancy histories until they can qualify for a lease in their own name. Three of the reinvestment strategies focus on the provision of housing-related management and move-in costs and services including: 1) housing clearinghouse services to manage referrals to housing and services, 2) contingency funds to cover housing-related costs such as security deposits and 3) startup funding for supportive services, which include ongoing housing-related services and supports that are Medicaid reimbursable and for one-time housing related services and management that are not reimbursable.

Since the implementation of the county-based Housing Plans, county human services agencies have invested over \$120 million to serve an estimated 3,300 OMHSAS priority consumers in PSH settings.

Conclusion

A safe place to call home is essential to recovery from behavioral health conditions. As such, behavioral health authorities and community behavioral health organizations are increasingly examining ways to meet the needs of individuals with severe mental illnesses (SMI) and/or substance use disorders (SUD), who often have co-occurring health conditions, have experienced homelessness, and are frequent users of costly institutional and emergency care. Permanent Supportive Housing (PSH) is a cost-effective, evidence-based intervention that – when matched with access to an array of community-based, flexible, and individualized services – promotes housing retention, improves health outcomes, and reduces costs.

For this approach to be successful, community behavioral health and supportive housing providers must team up, and community behavioral health organizations can explore and realize financing opportunities – through Medicaid – to provide housing-related supports and services. For more information on this paper or for additional resources, please contact Communications@thenationalcouncil.org.



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