

Assisting Medicaid beneficiaries to achieve housing stability

State options and potential flexibility available through Medicaid waivers

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Policy makers and Medicaid administrators realize the value in achieving housing security for Medicaid beneficiaries as a means of improving health outcomes and decreasing high-cost healthcare services. Housing security is a social determinant of health, playing a major role in influencing a person's health and well-being. To that end, the federal and state governments are pursuing ways to provide Medicaid beneficiaries with a variety of housing-related services.

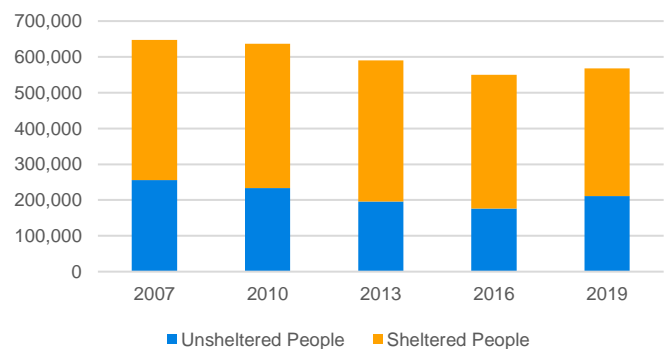
This brief scopes out the issue of homelessness and housing insecurity and Medicaid's role in addressing the issue. In particular, we outline existing Medicaid options, including state examples, for supportive housing services through waivers and other potential flexibilities available under Medicaid. We discuss potential options allowed under current Section 1115 Demonstration Waivers and the new Healthy Adult Opportunity. These mechanisms may present a path forward for achieving housing stability for our most vulnerable populations. This includes services designed not only to secure, but also to maintain, housing. Lastly, we point out key considerations for states developing or enhancing supportive housing programs.

Housing insecurity: Scope of the issue

The scope of homelessness and housing insecurity as an issue is substantial. According to the U.S. Department of Housing and Urban Development (HUD) 2019 point-in-time estimates, approximately 568,000 people around the country are homeless on any one night. Around two-thirds (63%) stay in emergency shelters or transitional housing programs, while the remaining third (37%) reside in unsheltered settings (e.g., in the streets, under bridges, in abandoned buildings, in cars, etc.). Over 96,000 individuals (17% of the total homeless population) are experiencing chronic homelessness. For the chronically

homeless population, the ratio of sheltered to unsheltered is reversed, with two-thirds living in unsheltered settings. Figure 1 illustrates the change in the estimates of people experiencing homelessness from 2007 to 2019.¹

FIGURE 1: SHELTERED AND UNSHELTERED HOMELESSNESS TRENDS, 2007-2019



Overall, sheltered homelessness decreased by 9% from 2007 and 2019 and has declined every year since 2014. Unsheltered homelessness has declined 17% since 2007 but has been on the increase every year over the last four years. These recent increases in unsheltered homelessness have been driven primarily by material increases in West Coast states.²

Not surprisingly, healthcare expenditures for individuals experiencing homelessness exceed those for the average Medicaid beneficiary. In Massachusetts for example, annual healthcare expenditures for individuals experiencing homelessness were estimated to exceed \$26,000 in total annual costs³ compared to about \$7,500 on average per Medicaid enrollee.⁴ Evidence indicates that providing Medicaid beneficiaries experiencing homelessness with stable housing can both improve health outcomes and decrease healthcare utilization and cost. One study of individuals experiencing chronic homelessness found that becoming housed led to a statistically significant decrease in reported emergency department use.⁵ The odds of reported emergency department use for participants receiving the study's comprehensive supportive housing services were 22% less than the odds of reported emergency department use for participants receiving only generally available community services.⁶

Homelessness and housing insecurity are also associated with poor health or health outcomes.⁷ Poor housing conditions can result in infectious and chronic disease, injury, and mental health conditions.⁸ For example, in children, poor housing conditions can lead to exposure to harmful toxins, such as lead, that may impact development.⁹ Individuals experiencing homelessness are likely to struggle more frequently with mental illness, substance use disorder, disabilities, and other conditions, and thus are heavier users of acute care services.¹⁰ Because of their challenging living situations, they are also more likely to use acute care services repeatedly. Patients experiencing homelessness have significantly higher readmission rates following hospitalization, with 70% of inpatient stays resulting in another inpatient admission, observation status stay, or emergency department visit within 30 days of hospital discharge.¹¹ For comparison, a 2014 analysis of all-cause readmissions in the general population found that only 14% of inpatient stays resulted in readmission within 30 days.¹² In addition, patients with housing have shorter hospital stays than patients experiencing homelessness.¹³

Federal guidance regarding use of Medicaid funds for housing

Using Medicaid funds to pay directly for housing, such as rent, has long been prohibited by the Social Security Act. However, Medicaid does allow for payment for services to support certain beneficiaries as they seek and try to maintain stable housing. These services are called “supportive housing services” (also referred to as permanent supportive housing) and include elements such as assistance in finding, obtaining, and retaining housing and to support transitions from institutional settings into the community.¹⁴ Various Medicaid programs around the country have been providing supportive housing services to Medicaid beneficiaries for many years.¹⁵

In recent years, the Centers for Medicare and Medicaid Services (CMS) has provided further guidance on supportive housing services. In 2015, CMS released an informational bulletin outlining three categories of services as discussed below:¹⁶

“Individual Housing Transition Services” are defined as direct support to individuals with disabilities, older adults needing long-term services and supports (LTSS), and those experiencing chronic homelessness. Examples of services include:

- Conducting tenant screening and housing assessments
- Assisting with housing applications
- Developing housing support plans, including services that may or may not be covered by Medicaid
- Identifying resources to cover expenses, such as security deposits or moving costs
- Assessing living environment to ensure it is safe for move-in

Housing Status Terminology

Housing instability: A broad term referring to individuals who have some form of housing but who are not able to sustain permanent housing. For example, individuals facing eviction due to nonpayment of rent. These individuals may be considered “at risk” for homelessness.

Homeless: According to HUD definitions, this term “describes a person who lacks a fixed, regular, and adequate nighttime residence.”

Sheltered homelessness: Homeless individuals “staying in emergency shelters, transitional housing programs, or safe havens.”

Unsheltered homelessness: Homeless individuals whose “primary nighttime location is a public or private place not designated for, or ordinarily used as a regular sleeping accommodation for people (for example, the streets, vehicles, or parks).”

Chronically homeless individual: According to HUD definitions, this term refers to “an individual with a disability who has been continuously homeless for one year or more or has experienced at least four episodes of homelessness in the last three years where the combined length of time homeless in those occasions is at least 12 months.”

Individuals “at-risk for chronic homelessness” include those with physical disabilities, mental illness, substance use disorders, or other medical conditions, often co-occurring.

Sources: Henry, M., Watt, R., Mahathay, A., Ouellette, J., Sittler, A., (Abt Associates). The 2019 Annual Homeless Assessment Report (AHAR) to Congress, Part 1: Point-In-Time Estimates of Homelessness. The U.S. Department of Housing and Urban Development. January 2020. Available at <https://files.hudexchange.info/resources/documents/2019-AHAR-Part-1.pdf>.

Chronically Homeless, National Alliance to End Homelessness, Updated January 2020. Available at <https://endhomelessness.org/homelessness-in-america/who-experiences-homelessness/chronically-homeless/>.

“Individual Housing and Tenancy Sustaining Services” are those services that support the tenant once housing is secured. These services are intended to support community integration and housing success. Examples of services include:

- Identification of risky behavior, such as late rental payments or other violations of the rental agreement, and intervention to prevent loss of housing
- Education and training on the landlord-tenant relationship
- Linkage with community resources to prevent eviction
- Assistance with housing recertification process

“State-Level Housing Related Collaborative Activities” are activities designed to assist in identifying and securing housing resources. Examples of services include:

- Developing agreements and relationships with state and local housing and community development agencies to facilitate access to housing resources
- Working with housing partners to create and identify opportunities for housing options for people wishing to transition by sharing data or developing tracking systems

To give a collaborative interagency example, the Massachusetts Community Support Program for People Experiencing Chronic Homelessness (CSPECH) is a partnership between the state’s Medicaid program (MassHealth), behavioral health managed care entity (Massachusetts Behavioral Health Partnership), and the Massachusetts Housing and Shelter Alliance. CSPECH was built upon an existing Section 1115 Waiver that was modified to serve the chronically homeless population.¹⁷ CSPECH leverages Medicaid to reimburse support services in supportive housing programs for individuals experiencing chronic homelessness. Covered support services, delivered through a community-based team approach, include activities such as outreach and engagement, service linkage, housing search, landlord communication, and daily living skills assistance. The CSPECH benefit is required to be covered by all managed care organizations through the Pay for Success initiative. Providers can be reimbursed up to 90 days in advance of a beneficiary becoming housed, allowing them time to identify housing and subsidy options, and services remain reimbursable for the duration the beneficiary stays housed. Reductions in the cost of healthcare for those in supportive housing through this program have resulted in estimated average savings of \$10,000 per person per year.¹⁸

Existing waiver options to cover supportive housing services

States may work with CMS to provide supportive housing services through Section 1915(i) State Plan and Section 1915(c) Home & Community-Based Services (HCBS) Waivers as well as Section 1115 Demonstration Waivers.

- Section 1915(c) Waivers are intended to be used for persons who are institutionalized or who would be considered eligible for institutional-based services in the absence of services included in the waiver. States must demonstrate that providing services within the home or community-based setting would not cost more than if the services were provided in an institutional setting. This option allows states to waive “statewideness” requirements, which means states can limit the program to specific geographic areas (e.g., based on needs and provider availability). States can also waive “comparability of services.” For example, states can limit services for beneficiaries with specific diagnoses such as behavioral health conditions.

- Section 1915(i) Waivers (also referred to as State Plan HCBS benefits) are an optional program states may include in their regular state plans (through a state plan amendment). Unlike the 1915(c) Waiver, the 1915(i) HCBS benefit does not have to be cost-neutral (i.e., be the same costs if the beneficiary were receiving care in an institutional setting). However, states must be able to sustain their portions of the cost. The statewideness rule may not be waived, so the benefit may not be limited to specific geographies, and enrollment may not be capped. States are permitted to limit exposure (e.g., due to greater than expected caseloads) by limiting eligibility to specific populations meeting clinical criteria. Eligibility is also restricted to beneficiaries with incomes at or below 150% of the federal poverty level (FPL).
- Section 1115 Waivers give states the most ability to be innovative in developing a range of initiatives to address healthcare services, healthcare utilization and costs, delivery system reform, and to improve quality and outcomes for Medicaid beneficiaries. The waiver application process calls for state resources to effectively plan and develop the application, as well as negotiate with CMS for approval. Section 1115 Waivers require states to demonstrate budget neutrality, meaning the overall Medicaid spend under the waiver would be no greater than what the Medicaid spend would likely have been absent the demonstration.

Selecting the optimal waiver vehicle is dependent on policy goals and program design considerations further discussed in the last section of this brief. The appendix provides examples of various states’ activities in utilizing waivers to provide supportive housing services. While state goals and approaches may vary, we see a few commonalities. Currently, several states are using waivers to address the housing needs of those who are leaving institutions as a way to prevent homelessness. In states that are taking a “housing first” approach to improving health outcomes, waivers are helping support collaborative interagency efforts aimed at achieving housing for individuals experiencing housing insecurity. Waivers are also being used to bolster behavioral health services in several states to better meet the needs of individuals who have severe mental health and substance use disorders.

Evolving Section 1115 Waiver flexibility and the Healthy Adult Opportunity

In 2018, the U.S. Department of Health and Human Services (HHS) indicated its interest in providing “organizations more flexibility so they could pay a [Medicaid] beneficiary’s rent.”¹⁹ Secretary Alex Azar noted that HHS is “actively exploring how we could experiment with actually paying for non-health services, like housing and nutrition—an integrated, individually driven

approach to health and human services on a scale that has never before been tried in the United States.”²⁰

EVOLVING SECTION 1115 WAIVER FLEXIBILITY

CMS’s recent approval of a North Carolina Section 1115 Waiver application further supports this new move by HHS to allow states to experiment and consider innovative strategies to integrate social determinants of health, including housing security.²¹ More specifically, North Carolina’s Section 1115 Waiver application included rental support in two instances in addition to other housing support services: paying for a beneficiary’s first month’s rent and providing housing for up to six months after a beneficiary is discharged from an inpatient psychiatric hospital. Medicaid coverage under this waiver will only be available if funding from other federal programs (e.g., HUD) is not available.

USING THE HEALTHY ADULT OPPORTUNITY TO EXPAND HOUSING SUPPORT

On January 30, 2020, CMS provided new state options in the guidance²² describing the new Healthy Adult Opportunity (HAO) Section 1115 Waiver option. This new waiver option provides the opportunity for states to address housing security and other social determinants of health in multiple ways. We have focused on two of them below.

Developing a targeted expansion to cover childless adults not traditionally covered by Medicaid

One of the unique opportunities available under a HAO demonstration is for states to apply for a targeted expansion of their Medicaid program, including those above 133% FPL. Under a HAO demonstration, states could prioritize eligibility for persons with targeted chronic conditions, e.g., serious mental illness (SMI), substance use disorder (SUD), or HIV/AIDS, and who are at risk of homelessness.

This waiver is similar to a Section 1915(i) Waiver, as described above, but would provide states with additional options that may make a program more sustainable. One of the challenges of a Section 1915(i) Waiver is that states may not be able to control the cost of the program because enrollment caps are prohibited. If states do not have the ability to establish spending levels for a program, they may not move forward with the initiative. The HAO demonstration provides income standard flexibility during the life of the waiver that could help states to adjust spending levels if a fixed amount of funding was appropriated for the program.

In addition to requiring states to provide the essential health benefits (EHBs) outlined in the Patient Protection and Affordable Care Act (ACA), CMS indicated that the HAO would provide states with “the ability to pay for services that cannot traditionally be funded by Medicaid, including those designed to address certain health determinants, such as enhanced case management services that link individuals to housing or other supports.”²³

Using shared savings from a HAO demonstration to invest in housing

Another key feature of a HAO demonstration is the ability to reinvest shared savings into important state initiatives. Although shared savings would be available under the targeted expansion, if a state opted to use an aggregate cap, establishing and maintaining shared savings programs may be more effective under a broader demonstration with more sizable expenditures and opportunity to achieve savings.

States have options under the HAO to use shared savings to create new initiatives that target the demonstration population or other Medicaid beneficiaries that would not otherwise be eligible for matching funds under the state plan or another demonstration, including providing allowable benefits and services designed to address certain social determinants of health.

It is still uncertain how much value states will perceive from the potential availability of shared savings because of the requirements to reinvest shared savings. A high-level summary of the shared savings requirements is outlined in a recent Milliman white paper²⁴ and additional information about shared savings can be found in the CMS guidance²⁵ on the HAO Section 1115 Waiver option.

Both the CMS approval of North Carolina’s Section 1115 Waiver and the guidance on the Healthy Adult Opportunity Section 1115 Waiver option signal CMS’s continued and evolving efforts to provide additional flexibility to states to address key social determinants of health like housing stability. States interested in leveraging these potential options, in addition to existing waiver opportunities, may be positioned to better address homelessness and housing insecurity.

Program design considerations

When developing programs to address housing security issues, there are several questions and decision points for states to consider. For instance:

- **What are the root causes for homelessness/housing insecurity in the state?** The approach for addressing the needs of this population with complex socioeconomic, acute healthcare, and behavioral healthcare needs will require understanding those needs at a detailed level. For example, are individuals who are discharged from an acute psychiatric hospital at high risk for homelessness, and if so, would they benefit from a targeted housing-related intervention? Collecting qualitative data from healthcare providers, social service providers, the law enforcement/justice system, and potential beneficiaries themselves are also important steps for effective program design.

- **What are the goals for related initiatives?** Based on the root cause analysis, the state should formulate goals that align with the Medicaid Quality Strategy²⁶ as well as other strategic public health goals established at the state or local level.
- **What is the target population and eligibility criteria?** Will the program be designed to narrowly target a population or is it intended to target a broader population? How will those individuals be identified? Conducting a data analysis to identify the potential population is a key step. This could include those who are flagged on assessment data or a healthcare claim as homeless (ICD-10-CM diagnosis code Z59.0); or those who are “frequent flyers” in the emergency department.

A useful resource made available by HUD recommends that states consider housing status, health conditions, and costs associated with the population when making program design decisions.²⁷ For example, the eligibility criteria can be limited to those who are chronically homeless or at risk for chronic homelessness. Alternatively, the program could focus on individuals who are released from an institutional setting or recently incarcerated. Eligibility criteria may be limited to those with mental health and substance use disorders and who have had a psychiatric inpatient stay. From a system cost perspective, the program could be designed to target beneficiaries with complex care needs and high costs.²⁸ Additionally, a state can select a combination of eligibility criteria to best enroll members who are most likely to benefit from the program.
- **What services will be included and who are the service providers?** A key decision point is what services will be included in the overall package. As discussed earlier in this brief, states will need to determine whether services will be *transitional*, *sustaining*, or both. For example, among transitional services, will there be housing search and application assistance, moving expenses, etc.? Among sustaining services, will there be coaching for developing and maintaining relationships with landlords to sustain tenancy and related training? Services such as case management and care coordination should be considered to support patient navigation and links to community resources to help retain housing. Effectively providing these services requires consideration of the providers and workers engaged in service delivery. For example, community health workers with cultural competencies and experience supporting vulnerable populations could be engaged to conduct outreach and provide informal counseling, intake, and initial health screenings.
- **What interagency collaborations are necessary to fulfill specific operational needs and meet program goals?** For example, can agencies share data with each other and link beneficiary information? Are local counties engaged to identify the population and share data? Are appropriate local and federal resources of HUD engaged to identify opportunities to improve administrative efficiencies (e.g., streamline application processes), reduce barriers to resources, or identify funding sources? By partnering with housing authorities, the Medicaid agency can access national programs like Section 8, Low-Income Housing Tax Credits, or McKinney Vento Homeless Assistance Grants.²⁹ If the program is working with post-incarcerated individuals, are interagency agreements in place with state departments of corrections and justice departments to identify and enroll eligible individuals?
- **What are the potential impacts to the Medicaid program and the state budget as a whole?** Projections to assess the programmatic costs and impacts on the Medicaid program and the state’s share of cost are necessary for sound fiscal planning. In addition, as discussed above, each waiver has varying cost restrictions—budget neutrality under Section 1115 Waivers, cost-effectiveness under Section 1915(c) Waivers, and the ability to sustain the state’s share of costs under Section 1915(i) Waivers. However, there are also cross-sector considerations that may drive increased spending in some sectors but decreased spending in others. For example, social services costs may increase in the short term but healthcare costs (e.g., emergency department visits) may decrease. Other social costs associated with housing insecurity are harder to quantify but are worth assessing when evaluating programs or assessing the value of a policy intervention. Measures include missed days of school or work, increased productivity, and decreases in caregiver fatigue.
- **What is the appropriate vehicle for obtaining authority to pay for supportive housing services?** Certain waiver vehicles may be better suited for an initiative or program the state is trying to put into place. For example, a pilot program may lend itself to a Section 1115 Waiver, but budget neutrality requirements would have to be satisfied. Specific waiver or state plan amendment requirements and the timeline for federal approvals should be considered as part of the overall decision-making and planning efforts.

- **What are considerations for managed care rate setting and MLR purposes?** States operating under a managed care environment would need to consider, as part of the capitated rate development process, the treatment of supportive housing services (as well as other services designed to address social determinants of health). Rules regarding actuarial soundness and managed care certification only allow the inclusion of state plan services or waiver services approved by CMS. Therefore, all supportive housing services would need to be approved with the applicable waiver authority by CMS before being included in the capitation rates. Even if some services may be allowed, there may be other services and/or other health plan investments that are not permissible to include in the capitation rates because of administrative and legal challenges. The American Academy of Actuaries provided some initial potential recommendations to CMS regarding this issue, including formalizing guidance to count services designed to address social determinant of health factors as part of the numerator for medical loss ratio (MLR) calculations and providing flexibility for states to include all or a portion of the cost of services avoided as a result of social determinant of health investments in the capitation rates.³⁰
- **What services are included?** For example, is only one month of rent (security deposit) included, or is more extended support available? Are services such as furniture and furnishings included? What one-time (move-in) costs are included? For example, security deposits, utility set-up fees, pest control, or fumigation? Will any ongoing rental costs be included, such as tenancy support services or case management supports?
- **What are the benefit limitations?** For example, will participation be limited to a certain time period?
- **What are the cost estimates assuming budget neutrality?** Are there any expected savings resulting from the waiver initiatives?

Moving forward

Housing stability is one of the most influential and basic social determinants of health. As CMS recognition of the importance of housing supportive services translates to increased options for states to cover these services, more can be done to advance innovative Medicaid solutions for housing stability for beneficiaries. States are encouraged to consider the above options to streamline clinical and social services and expand Medicaid's housing impact on the health outcomes of vulnerable populations and the high cost of the care they receive.

For a Section 1115 Waiver application, in addition to the questions above, the following are also important considerations:

- **What regions will be included?** A related question is whether the initiative will be administered as regional pilots or statewide.
- **What entity will serve as the lead?** For example, depending on the state and the initiative, the lead entities may be managed care organization, behavioral healthcare organizations, or provider-led organizations. Will interactions with community-based organizations be optional or required?



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APPENDIX: WAIVERS TO ADDRESS HOMELESSNESS AND HOUSING INSECURITY THROUGH MEDICAID: EXAMPLES FROM STATES

The table below provides examples from select states. It is not a comprehensive list of all the ways states are leveraging Medicaid waivers to address homelessness and housing insecurity.

| SECTION 1915(I) STATE PLAN AMENDMENTS HCBS WAIVERS | | | | |
|--|--|-----------------------------------|--|---|
| STATE | GOAL | STATUS | TARGET POPULATION | SCOPE OF SERVICES |
| Michigan 18-0008 | Deliver needed supports and services to individuals transitioning to living in the community following institutionalization | Effective 10/1/2018 – 9/30/2023 | Individuals aged 65 and over and/or disabled transitioning from nursing facilities or other institutional settings to community settings | <p><u>Transition Navigator Case Management Services</u></p> <p>Provides transition services that are specified in the individual's person-centered treatment plan and that no other qualified provider is willing or able to provide (e.g., housing search and application, HCBS enrollment)</p> <p><u>Community Transition Services</u></p> <p>Covers nonrecurring expenses needed to aid transition (e.g., security deposits, essential furniture, pest eradication)</p> <p><u>Home Modifications</u></p> <p>Includes physical changes to home required to ensure the individual's health and welfare (e.g., accessibility ramps, electric work needed for medical equipment)</p> |
| Texas 14-0014 | Support individuals in recovery to transition into their own residences according to their preferences and needs | Effective 9/1/2015 – 8/31/2020 | Elderly and disabled individuals transitioning from institutions to community settings | <p><u>Transition Assistance Services</u></p> <p>Covers expenses needed to establish basic household (e.g., security deposits) and promote the individual's health and welfare (e.g., pest eradication)</p> <p><u>Minor Home Modifications</u></p> <p>Covers physical adaptations to the individual's home where, without the modifications, the individual would have been institutionalized (e.g., widening of doorways, ramps)</p> |
| SECTION 1915(C) HCBS WAIVERS | | | | |
| STATE | GOAL | STATUS | TARGET POPULATION | SCOPE OF SERVICES |
| Alabama 0001.R08.00 | Help participants maintain housing according to their approved plans of care in a home or community setting | Effective 10/01/2019 – 09/30/2024 | Individuals 3 years of age and older with intellectual disabilities moving to living in the community | <p><u>Housing Stabilization Service</u></p> <p>Covers a range of housing coordination activities (e.g., residential habilitation, crisis intervention, housing stabilization, occupational therapy, prevocational services)</p> |
| Maryland 0023.R07.00 | Provide time-limited supports covering a range of housing coordination activities to help individuals secure housing | Effective 07/01/2018 – 06/30/2023 | Individuals of any age with developmental disabilities | <p><u>Housing Information and Assistance Services</u></p> <p>Helps in obtaining and renting independent housing (e.g., identifying resources for moving costs, reviewing the lease)</p> <p><u>Housing Transition Services</u></p> <p>To assess housing needs and formulate a housing support plan based on the individual's needs (e.g., tenant screenings, prevention and early intervention services to implement should housing become jeopardized)</p> <p><u>Housing Tenancy Sustaining Services</u></p> <p>Services that aid individuals in maintaining living in their homes (e.g., education on how to be a good tenant, landlord dispute resolution, eviction prevention)</p> |
| SECTION 1115 DEMONSTRATION WAIVERS | | | | |
| STATE | GOAL | STATUS | TARGET POPULATION | SCOPE OF SERVICES |
| California 11-W-00193/9 | Test whether local initiatives coordinating physical health, behavioral health, and social services can improve health outcomes and reduce medical costs | Effective 12/30/2015 – 12/31/2020 | Medi-Cal beneficiaries in participating counties, criteria differ per pilot program | <p>Whole Person Care Pilot Program</p> <p>A majority of the 25 pilots within the program offer housing supportive services, including navigation and tenancy support, in an effort to help enrollees find housing placements and stay in them for the long-term. Midpoint evaluation showed early success associated with pilots that had developed partnerships with the local housing authority to ensure that a specified number of Section 8 vouchers are set aside for program enrollees. Other promising methods included flexible housing pools funded by the pilot programs, partners, and community entities to pay for security deposits, application fees, or rental subsidies.</p> |

| SECTION 1115 DEMONSTRATION WAIVERS | | | | |
|--------------------------------------|---|---|---|---|
| STATE | GOAL | STATUS | TARGET POPULATION | SCOPE OF SERVICES |
| Florida 11-W-00206/4 | Improve health outcomes for participants through the facilitation of housing stability | Launched 12/01/2019 | Individuals 21 years of age and older who are homeless or at risk of homelessness and have a serious mental illness and/or substance use disorder residing in one of six counties covered by the pilot | <p>Housing Assistance Pilot</p> <p><u>Transitional Housing Services</u></p> <p>Includes activities associated with preparing for and transitioning into housing (e.g., tenant screening, forming an individualized housing support plan, housing search and application, financial resource identification, housing safety evaluation)</p> <p><u>Tenancy Sustaining Services</u></p> <p>Covers services that support participants in being successful tenants (e.g., identifying and reducing risky behaviors, tenant and landlord education, landlord relationship coaching, landlord and neighbor dispute resolution, linkage to community resources)</p> <p><u>Mobile Crisis Management</u></p> <p>Immediate, intensive, on-site intervention provided by a behavioral health professional to participants experiencing a behavioral health crisis</p> <p><u>Self-Help/Peer Support</u></p> <p>Provides for peer support specialists to work with participants to develop community living skills and help manage their SUD or SMI symptoms</p> <p><u>Incidental Coverage</u></p> <p>One-time payment for moving expenses such as deposit(s).</p> |
| Hawaii 11-W-00001/9 | Improve health outcomes, increase care coordination effectiveness, and decrease costs by lowering emergency department usage by connecting individuals experiencing homelessness or at risk of homelessness with housing services | Effective 08/01/2019 – 07/31/2024 | Individuals experiencing homelessness or at risk of homelessness with a behavioral health need (mental health or substance use) or a complex physical health need | <p>Community Transition Services Pilot Program</p> <p><u>Transitional Case Management Services</u></p> <p>Funding for activities around assisting the individual with moving into stable housing (e.g., planning the move, assessing move-in readiness, non-monetary assistance obtaining furniture, one-time utility set-up costs)</p> <p><u>Housing Quality and Safety Improvement Services</u></p> <p>Covers repairs, remediation, or modifications for issues that provide cost-effective methods for ensuring or improving the individual's health condition within the housing (e.g., mold abatement, pest eradication, installing accessibility features)</p> <p><u>Legal Assistance</u></p> <p>Connection to community resources for help addressing legal issues impacting housing, such as assistance breaking a lease due to unhealthy living conditions</p> <p><u>Securing Housing Payments</u></p> <p>Provides for the one-time payment of security deposits and/or first month's rent, if funding is not available through other programs</p> |
| Illinois 11-W-00316/5 | Enable treatment in the community through housing stability for a chronically ill population experiencing housing instability | Effective 07/01/2018 – 06/30/2023 | Individuals at risk of homelessness or institutionalization with two or more chronic conditions (including physical health and mental health-related conditions) and more than four emergency department visits in a year | <p>Behavioral Health Transformation Demonstration Assistance in Community Integration Services Pilot</p> <p><u>Pre-Tenancy Supports</u></p> <p>Provides for activities related to readying individuals for receiving care in the community (e.g., needs assessment, connection to social services)</p> <p><u>Tenancy Sustaining Services</u></p> <p>Covers activities related to preserving independent living (e.g., skills coaching, landlord communication, crisis planning)</p> |
| Massachusetts 11-W-00030/1 | Reform delivery systems and payment methods to promote integrated, coordinated care while holding providers accountable for the cost and quality of care | January 2020 anticipated launch | MassHealth Accountable Care Organization (ACO) members who 1) have a behavioral health or complex physical health need, repeated emergency department use within a timeframe, high-risk pregnancy, or require assistance with Activities of Daily Living or Instrumental Activities of Daily Living, and 2) are homeless, or at | <p>Flexible Service Program</p> <p>Funds evidence-based pilot approaches to addressing health-related social needs within the domains of housing supports and nutrition by providing these supports directly through ACOs or through community-based organizations</p> <p><u>Pre-Tenancy Supports</u></p> <p>Covers fees associated with housing applications and nonrecurring household set-up costs, including first and last month rent</p> <p><u>Tenancy Sustaining Supports</u></p> <p>Includes activities related to supporting the tenant's success in maintaining housing (e.g., landlord communication assistance, lease compliance training, independent living skills coaching)</p> |

risk for homelessness or food insecurity

| SECTION 1115 DEMONSTRATION WAIVERS | | | | |
|--------------------------------------|--|-----------------------------------|---|---|
| STATE | GOAL | STATUS | TARGET POPULATION | SCOPE OF SERVICES |
| Massachusetts (continued) | | | | <p><u>Home Modifications</u></p> <p>Provides for alterations that will promote the tenant’s health and safety (e.g., accessibility hand shower and railing installation, home environmental risk assessments)</p> <p><u>Nutrition Sustaining Supports</u></p> <p>Covers assistance with obtaining and maintaining nutritional benefits, provision of cooking supplies for meeting nutrition and diet needs, nutrition education, transportation to the grocery store, meals delivered to the home</p> |
| North Carolina 11-W00313/4 | Integrate physical health, behavioral health, and pharmacy services to create streamlined access to all benefits | Effective 11/01/2019 – 10/31/2024 | <p>Individuals with housing, food, or transportation insecurity or who are at risk for experiencing interpersonal violence.</p> <p>Adults 21+ with two or more chronic conditions (e.g., obesity, substance use disorder, mental illness, cardiovascular disease, etc.) and more than four emergency department visits in a year or repeated hospital admissions.</p> <p>At-risk pregnant women—those with complicating conditions (such as hypertension or mental illness), over 40 or under 15, or currently using drugs or alcohol.</p> <p>Premature infants or those born with low birth weight or who screen positive for maternal depression.</p> <p>Children with one or more uncontrolled chronic conditions (e.g., diabetes, asthma, mental health diagnosis, substance use disorder) or are in foster care.</p> | <p>Enhanced Case Management Pilot Services</p> <p>Covers evidence-based nonmedical services that address specific social needs linked to health and health outcomes such as housing instability, transportation insecurity, food insecurity, interpersonal violence, and toxic stress</p> <p><u>Tenancy Support and Sustaining Services</u></p> <p>Prepare individuals for the transition to housing and support them in maintaining housing through integration and inclusion in the community (e.g., living skills coaching, financial counseling, crisis plan formation, utility set-up)</p> <p><u>Housing Quality and Safety Improvement Services</u></p> <p>Provides funds to cover reasonable and necessary home repair and accessibility modification expenses that individuals cannot cover on their own and that are not covered by other programs or provisions (e.g., mold abatement, pest eradication, grip bars in bathtubs, wheelchair ramps)</p> <p><u>Securing House Payments</u></p> <p>One-time payment of security deposit and first month’s rent, if funding is not available through other programs</p> <p><u>Short-Term Post-Hospitalization:</u></p> <p>Provides post-hospitalization housing, not to exceed six months, for individuals at risk of homelessness upon discharge. If temporary housing services are available through another program, this service covers connecting individuals to that program.</p> |

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 California: https://harbageconsulting.com/wp-content/uploads/2019/03/Harbage_WPC_MidPointPaper.pdf
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Endnotes

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