Improving Minnesota's Housing Stabilization Services Benefit

Advancing Housing Solutions for a More Secure and Equitable Minnesota

August 2024

PSC

PUBLIC SECTOR
CONSULTANTS

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Public Sector Consultants
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Prepared for

Minnesota Department of Human Services
https://mn.gov/dhs/

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Overview

The Minnesota Department of Human Services (DHS), in partnership with Minnesota Housing, the state's housing finance agency (MHFA), introduced a new Medical Assistance (MA) benefit, called Housing Stabilization Services (HSS), in 2020. HSS is a set of 1915(i) Home- and Community-Based Services implemented by DHS as part of MA, the state's Medicaid program, intended to help individuals approved for MA find and keep housing.

After four years of implementation and through dramatic program growth, DHS and Minnesota Housing identified the need for programmatic and service improvements. The number of individuals enrolled in HSS has increased more than nine times between 2020 and 2023. Minnesota's HSS benefit was one of the first of its kind to be approved by the Center for Medicare & Medicaid Services (CMS). Since then, CMS has approved a broader array of state plan amendments and waivers for states to support housing-related needs, opening new possibilities for improving Minnesota's HSS benefit.

DHS and Minnesota Housing partnered with Public Sector Consultants (PSC) and Health Management Associates (HMA), nonpartisan public policy research firms, to conduct stakeholder engagement and research to inform the benefit redesign possibilities. These activities build on the significant amount of research and stakeholder engagement done by DHS, Minnesota Housing, and other invested partners such as the Minnesota Interagency Council on Homelessness during the first years of implementation. These efforts include ongoing dialogue with HSS recipients, providers, and DHS staff reviewing HSS applications, community engagement sessions, and participating in the Housing and Services Partnership Accelerator (HSPA).[1]

The following report lays out the priority considerations for HSS benefit improvement, which were informed through stakeholder engagement of health and housing service providers and those with lived experience accessing the HSS benefit, in addition to an environmental scan of five other states and their approaches to administering an HSS benefit. The priority considerations for benefit improvement include:

- **Invest in strategies that improve the timeliness of application processing**
- **Enhance training and related tools to support providers administering the HSS benefit**
- **Reevaluate the current HSS payment structure and billing processes**
- **Reduce administrative complexity**

[1] The HSPA is a cohort of states with similar Medicaid-covered housing benefits supported by, and facilitated through, the Housing and Services Resource Center, founded as a partnership among the U.S. Department of Health and Human Services, the U.S. Department of Housing and Urban Development, and the U.S. Department of Agriculture.

Stakeholder Input

In collaboration with DHS and Minnesota Housing (the MN project team), PSC and HMA held two online stakeholder listening sessions to gather feedback regarding the HSS benefit. The two main groups engaged through these sessions were health and housing service providers and those with lived experience of accessing the HSS benefit. To recruit participants, the MN project team gave health and housing service providers advance notice prior to sending invitations by distributing information about the upcoming listening session in a newsletter and structuring a survey with the option for participants to opt-in to additional engagement opportunities.

The MN project team also sent invitations directly to thousands of health and housing providers and hundreds of individuals with lived experience. The invitation to health and housing providers also included language for the providers to send to any known clients or interested individuals with lived experience. The listening session invitations prompted a robust response, especially from health and housing providers, with over 550 registrants for the listening session, demonstrating an intense community interest in the improvement of the HSS benefit. These health and housing providers included representatives such as HSS providers, community-based organizations, tribal representatives, municipal partners, health systems, faith-based organizations, and behavioral health and supportive housing providers.

On August 6, 2024, the MN project team, PSC, and HMA hosted the first online listening sessions. Over 320 health and housing service providers attended the listening session, during which they heard an overview of the feedback the MN project team had received thus far. Additionally, the participants were divided into small group discussions via breakout rooms. Each breakout room was facilitated by PSC, HMA, or staff from Minnesota's Management and Budget team and focused on eliciting feedback about their recommendations for how Minnesota should revise its HSS benefit. On August 9, 2024, more than 20 individuals with lived experience joined for the second listening session. Similar to the first session, participants received an overview of current feedback and broke into small, facilitated groups to discuss their recommendations for improving the HSS benefit. After each session, the presentation materials and a recording of the session were distributed to all registrants for their reference.

Stakeholder Feedback Themes

Several clear themes emerged from PSC's engagement work that asked providers and those with lived experience how the HSS benefit could be improved. The themes closely align with and reinforce findings from previous studies and engagement efforts led by other housing-focused organizations, in particular:

- Corporation for Supportive Housing. *Housing Stabilization Services (HSS) TA Team: Two-Year Report and Recommendations* (in Appendix C)
- Hearth Connection, *Accessing and Maintaining Long-Term Solutions to Homelessness* (in Appendix D)

A summary of participant concerns about the HSS benefit and how these challenges affect providers and participants are described below.

Application Processing Timelines

Providers' most frequently requested change to the HSS benefit was improving processing timelines for initial HSS client applications, client renewals, and provider change requests. Current processing timelines cause a range of downstream impacts. Most obvious, but perhaps most concerning, is the barrier these delays create to clients' ability to access services in a timely manner. Providers reinforced that while delayed access to any type of service is significant given the vulnerabilities many clients face, it is particularly notable given the emergent nature of needs that often result from housing instability and homelessness, where immediate deployment of support and resources is critical.

Providers also noted that lengthy processing timelines pose significant challenges. They described having to regularly decide whether to forgo reimbursement to serve a client's emergent needs without HSS eligibility approval due to processing delays or to withhold critical services from the client until HSS eligibility is approved and reimbursement for the cost of services is assured. Lack of reimbursements and delayed reimbursements were consistently cited as factors contributing to growing concerns and skepticism among providers about being able to sustain delivery of HSS services.

Many providers stated they believed inadequate staff capacity was the root cause of delays, and further emphasized that the volume of processing work has simply exceeded the capacity of current staffing levels. Several providers and service recipients made a point to express appreciation for the work of State staff, with some acknowledging the pressure likely faced by staff working hard to keep up with such heavy workload demands over time. It is reasonable to assume the considerable influx of HSS applications reflects growing demand for the benefit. Therefore, investing in additional staff capacity is an important strategy to consider for the purpose of improving timely application processing.

Training

Providers identified the need for more consistent and comprehensive training coupled with more responsive on-demand program support to strengthen program integrity, compliance, and service quality. Providers expressed feeling inadequately prepared to administer HSS benefit without more robust training. Several forum participants recommended expanding training to staff other than housing service providers, such as waiver case managers, managed care organizations (MCO) care coordinators, and others who are likely to engage directly with HSS-eligible clients. These staff types are responsible for supporting clients' understanding of and access to HSS and other housing services when appropriate. Additionally, enhanced training for state staff responsible for addressing provider HSS policy and operational inquiries was a noted recommendation partly driven by provider experiences receiving conflicting guidance from different DHS staff.

Administrative Complexity

Providers and those with lived experience consistently described HSS policies, eligibility rules, and operational workflows as overly complex and difficult to manage and navigate. One forum participant with lived experienced noted, "The HSS benefit is awesome on its face but challenging in practice." For example, HSS policy restricts providers from delivering both housing consultation services and housing transition/support services to the same client. While a well-intended policy designed to prevent conflicts of interest, forum participants noted how it creates extra steps for clients to seek out new providers, which is particularly frustrating for clients whose preference is to maintain a relationship with the same provider throughout the continuum of HSS services needed. Forum participants also described how this rule leaves

clients vulnerable to exploitation by housing consultants who aren't diligent about ensuring their clients successfully connect to housing transition and sustaining service providers following development of a care plan. This aligns with concerns related to "predatory" providers that were called out in previous reports on the HSS benefit.

A similar example raised by forum participants relates to the requirement that clients access housing consultation services through an existing case manager if they have one (e.g., waiver case manager), rather than a new housing consultation service provider. Designed to promote service coordination and prevent billing Medicaid twice for the same service (often referred to as "double-dipping")—two important goals—providers described how the rule is difficult to abide by in practice. Without a shared data portal, providers find it difficult to identify when a client may already be connected to a case manager. This creates additional "hoops" for providers and clients to jump through that can disrupt timely access to services.

Additionally, participants reflected on how misalignment of program rules across different services compromises providers' ability to seamlessly coordinate the unique combination of housing and non-housing related services clients need to become stably housed. Forum participants described how the nuanced differences between Housing Support Services and Housing Stabilization Services are difficult to understand, as are the differences between home and community-based services and HSS services. As a result, and despite best intentions, providers are concerned clients are not always given accurate information or effective support to access services that best meet their individual needs. One participant with lived experience described the various housing programs operating in isolation from one another as "a cycle of dysfunction that's egregious in my opinion … because it isn't solving housing; it's actually creating homelessness."

Some forum participants currently enrolled in HSS said the administrative complexity makes it difficult for them to understand what's happening with their case. One person noted, "I feel in the dark; I just don't know what's going on" while another reinforced that sentiment stating, "A lot of times people don't even know who their case manager [or HSS provider] is." While these issues are not solely the result of program complexity, a myriad of participant comments suggested complexity was one of the primary causes. Finally, providers also commented on the complexity involved in the MN Health Care Programs provider enrollment process with DHS and the related credentialing process with each MCO, both of which are prerequisites to providing HSS services to individuals. The process was described as confusing to follow and onerous to complete.

Billing Rates and Reimbursement Processes

Several providers passionately described their difficulties navigating billing and reimbursement processes through MCOs. Specifically, some mentioned lacking the internal infrastructure necessary to manage complex billing and reimbursement processes. Some participants discussed the possibility of utilizing third party administrators for billing and managing claims, although these are not yet widely used across the country. Others noted that billing challenges are further complicated by variation in billing procedures across each managed care organization, and the requirement to bill in 15-minute increments. Collectively, these factors impacted billing and reimbursement processes in ways that providers characterized as burdensome and often too complex to effectively manage.

In addition to process concerns, forum participants also felt that current reimbursement rates do not adequately cover their costs to deliver services. Some expressed concern that the current rate formula doesn't adequately take into consideration the operational realities involved in serving those experiencing housing instability or homelessness, such as the costs of travel to and from client meetings, or the possibility of clients "no-showing" to scheduled meetings with their worker. In both examples, the time spent by staff is not eligible for reimbursement despite the real costs incurred by providers.

Finally, providers emphasized that delays in DHS application processing timelines, coupled with MCO invoice processing delays, have impacted cash flow for many providers. The combined impact of these issues has raised concerns among impacted HSS providers about being able to maintain their organization's financial solvency, leading , some to opt out of HSS service delivery as a result.

Impacts of Identified Challenges

An analysis of participant feedback found a significant, program-wide imbalance between the volume of work involved in administering the HSS benefit as currently designed, and the availability of sufficient resources to effectively manage that volume. The imbalance can significantly compromise program efficacy and create challenges for all who administer the program, deliver services, or seek access to the HSS benefit. The impacts of those challenges are many, including:

- Providers find it difficult to sustain delivery of the HSS benefit
- Program integrity and quality assurance are difficult and costly for the state to consistently monitor
- Providers struggle to understand and comply with program rules despite best intentions
- Providers face barriers in their efforts to provide whole-family, person-centered services
- Clients face restrictions in their ability to exercise choice and self-determination, especially about whether and what HSS services to access and with whom they'd like to work

Even with the multitude of identified challenges, providers and service recipients both agreed about the importance of and widespread need for HSS services. It should be noted that a significant number of housing providers and individuals with lived experience chose to participate in the hosted forums. The impressive engagement level indicates that the HSS benefit is highly valued. It also demonstrates that a strong contingent of housing providers and service recipients are interested in and committed to partnering with the State to improve overall benefit design, which validates the State's decision to prioritize and invest in this work.

Other State Research

HMA conducted research on four states and one district with a housing benefit like the Minnesota HSS benefit: Connecticut, Hawaii, North Carolina, Washington D.C., and Washington state. In addition to basic benefit background information, the research questions included the services associated with the benefit, the entity responsible for determining benefit eligibility, the target group of eligible individuals, the eligibility criteria, and reimbursement approaches. The complete research overview is available in Appendix A.

Considerations for Benefit Improvement

The following considerations were informed by the stakeholder input, the themes identified therein, and the other state research conducted. The considerations include strategies for the State to consider as it seeks to resolve an imbalance between workload demands and staff capacity, as outlined in the stakeholder input. The considerations fall within three categories:

1. Adding capacity
2. Reducing demand
3. Creating efficiencies through simplification and streamlining.

The considerations are listed in priority order in view of immediate and longer-term program improvement efforts.

1 Priority One: Invest in Strategies That Improve the Timeliness of Application Processing

Application processing delays have troubling consequences that go beyond limiting clients' timely access to services. Often the delays create additional work, further compounding the problem. For these reasons, addressing the processing delays is an important priority for the immediate term that will likely serve to mitigate several of the concerns raised by forum participants, in addition to improving processing timeliness.

Strategies to Consider

1. Invest in additional staff to support the volume of work.
2. Review the caseworker division of labor to determine possible changes.
3. Procure feedback from providers and participants about the best way to navigate prioritizing applications, while being mindful of the tradeoffs between the current approach and alternatives.

2 Priority Two: Enhance Training and Related Tools to Support Providers Administering the HSS Benefit

More comprehensive training and helpful tools will improve provider understanding of program rules, promote operational best practices and demonstrate responsiveness to provider needs. Additionally, training is likely to reduce the volume of provider and client questions for DHS, as well as the volume of re-work required when forms or other documents are not completed correctly.

Strategies to Consider

1. Contract with an external organization to develop and facilitate HSS training to address DHS capacity challenges. This will avoid adding additional training responsibilities to already overburdened state staff.
2. Expand the availability of training beyond HSS providers to include waiver case managers, MCO care coordinators, and others who support clients likely eligible for HSS or related services.
3. Provide ongoing enrollment support to providers without experience as Medicaid service providers to eliminate enrollment barriers and maximize provider capacity in the community.

3 Priority Three: Reevaluate the Current HSS Payment Structure and Billing Processes

The perceived inadequacy of current reimbursement rates along with concerns about the overall rate structure and design are prompting many providers to get out of the business of HSS service delivery. Appendix B provides a summary of findings from a high-level evaluation of Minnesota's current HSS rates. This summary can inform a more comprehensive rate evaluation with an emphasis on assessing the adequacy and overall design of HSS rates

Strategies to Consider

1. Eliminate rigid reimbursement eligibility requirements regarding the number of service hours that must be delivered in person versus remotely. Current rules prevent services from being delivered in ways that best support each service recipient and do not reflect the realities of the work involved in supporting individuals experiencing homelessness or housing instability.
2. Contract with an external organization to conduct a comprehensive evaluation of the adequacy of current reimbursement rates to account for inflation as well as other factors highlighted in the report available in Appendix B. As part of the rate assessment, consider the feasibility of the suggestions below as potential stand-alone strategies to address forum participants' concerns.
    a. Revise the 15-minute billing increment requirement to a more manageable increment (e.g., daily rate, per member per month).
    b. Reimburse travel time to and from in-person client meetings. A considerable amount of staff time—and therefore expense— can accrue, particularly for counties outside the metro area where communities are more geographically dispersed.
    c. Explore a tiered rate structure that allows for adjustment of reimbursement rates based on a defined set of factors such as service intensity, geographic considerations (e.g., regions with provider shortages, or less population density resulting in higher travel costs) or cultural considerations (e.g., Tribal members with housing needs).
3. Implement an inflationary rate increase in the immediate term while a more comprehensive rate study is conducted. No inflationary increases have been implemented since the rates were initially established in 2017.

4 Priority Four: Reduce Administrative Complexity

The current administrative complexity is costly to manage, difficult to navigate, and often creates barriers to access services.

Strategies to Consider

1. Conduct journey-mapping exercises using specific client personas to deepen understanding of the experiences of clients and front-line HSS service providers, and to uncover process and policy pain points that create unnecessary barriers to quality services. Use the results to identify "quick win" simplification opportunities that can be implemented more easily in the immediate term to provide some administrative relief to HSS providers and service recipients requiring lengthy planning or approval processes.
2. Leverage the legislatively mandated study on Medicaid Waivers and HRSNs to explore innovative ways that Medicaid Waiver Authority can be used to remove rigid program silos and promote more holistic, person-centered services that focus on the whole family, and can be customized to target individuals' unique needs across the spectrum of HRSNs.

Appendix A: Other State Research

Connecticut

State	Connecticut [2]	Authority	1915(i)
Title of Benefit and Year Benefit Began	Connecticut Housing Engagement and Support Services (CHESS) Initiative—planned mid-2020, delayed until mid-2021.[3]		
Entity Determining Eligibility	Contracted behavioral health administrative services organization (BH-ASO). Current contract is with Carelon.		
Projected Number Served	**Year one** (June 2020–May 2021): 200	**Year two** (June 2021–May 2022): 300	**Year three** (June 2022–May 2023): 850
Third-Party Administrator Involved in Billing?	Managed by contracted BH-ASO		

Services	Definition of Services and What It May/May Not Include	Target Group	Eligibility Criteria	Reimbursement
• Care plan development and monitoring • Pre-tenancy and transition supports • Housing and tenancy-sustaining services • Transportation	**Care plan development and monitoring** is provided to support the participant in the development of his or her person-centered recovery planning (PCRP) related to CHESS services. The participant leads the development of his or her planning process. The process includes a discussion related to the participant's goals and how the available services will best support the participant in achieving the goals. **Pre-tenancy and transition supports** are intended to assist the target population in moving from homelessness or higher level of supportive housing into community housing. Services are aligned with the participant's plan documented goals and include, but are not limited to: • Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy. The assessment may include collecting information on potential housing transition barriers and identification of housing retention barriers. • Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, including short- and long-term measurable goals for each issue, establishes the participant's approach to meeting the goals, and identifies when other providers or services, both reimbursed and not reimbursed by Medicaid, may be required to meet the goals. • Residential support such as motivating the participant to find and lease an apartment and assistance with tenancy issues and problems. • Landlord recruitment and advocacy, voucher and security deposit applications, apartment search, lease compliance education, assistance with tenant inspection, and lease signing. • Finding and choosing a place to live, meeting housing eligibility requirements as needed, negotiating landlord/neighbor relationships and understanding and maintaining rights of tenancy. • Assistance in obtaining required ID. • Assisting with the housing application process and housing search process. • Identifying resources to cover expenses such as security deposit, moving costs, furnishings, adaptive aids, environmental modifications, and other one-time expenses. • Ensuring that the living environment is safe and ready for move-in.	Medicaid-enrolled individuals who meet all the following: • Age 18 and over. • Disability and/or disabling condition, including homelessness. • Diagnosis of homelessness defined as category 1 or category 4 of HUD's definition of homelessness as defined in 24 CFR § 583.5, including diagnosis of homelessness not more than 12 months prior to institutionalization. For participants who are institutionalized, determination of homelessness not more than 12 months prior to institutionalization will be based on one or more of the following, to the extent applicable to each individual: ◦ To the extent available, the preference is to obtain applicable documentation provided under the HUD recordkeeping requirements in 24 CFR § 583.301(b). ◦ Documentation within the State's Homeless Management Information System. ◦ Evidence of homelessness through self-certification. • Risk score as defined by Healthcare Effectiveness Data and Information Set (HEDIS) Plan All-Cause Readmissions measure, which is a combination of diagnoses for individuals with inpatient hospital utilization, which is a method of measuring disability. • Has been determined to be most likely to benefit from the services included based on the following methodology, which uses a combination of measures of diagnoses and disability as described below. The methodology for determining the risk ratings of homeless individuals who are Medicaid eligible is based on the National Committee for Quality Assurance (NCQA) HEDIS Plan All-Cause Readmissions measure.	Participant must: 1. Meet the definition of homelessness described below or met the definition of homelessness not more than 12 months prior to institutionalization. 2. Have at least one critical need which is a manifestation of the participant's homelessness or institutionalization. 3. Have at least one additional critical need that may or may not be a manifestation of homelessness or institutionalization. Homelessness is defined as category one or category four of the HUD definition of homelessness in 24 CFR § 583.5. For participants who are institutionalized, determination of homelessness not more than 12 months prior to institutionalization will be based on one or more of the following, to the extent applicable to each individual: 1. To the extent available, the preference is to obtain applicable documentation provided under the HUD recordkeeping requirements in 24 CFR §583.301(b). 2. Documentation within the State's Homeless Management Information System. 3. Evidence of homelessness through self-certification. Critical needs are defined as the need for cues with activities of daily living or instrumental	**Care plan development and monitoring:** $200 annually **Pre-tenancy and transition supports**: Per member per month (PMPM) base payment of $747.75, with a PMPM add-on payment based on the provider's performance on specified outcome measures below: • Lease-up in housing equal to or less than 90 days of approved PCRP: $648.05. • Lease-up in housing between 91 and 120 days of approved PCRP: $448.65. • Lease-up in housing between 121 and 150 days of approved PCRP: $329.01. • Lease-up in housing between 151 and 180 days of approved PCRP: $249.25. • Lease-up after 180 days of approved PCRP: No payment above base payment.

[2] The State of Connecticut Department of Social Services. June 20, 2020. "Notice of Proposed Medicaid State Plan Amendment (SPA)." https://portal.ct.gov/-/media/departments-and-agencies/dss/spas/spa-20k--chess-initiative-sect-1915i-state-plan-hcbs--website-posting.pdf

[3] Connecticut Medical Assistance Program. Policy Transmittal 2021-45. Provider Bulletin 2021-85. October 2021. https://www.ctdssmap.com/CTPortal/Information/Get-Download-File?Filename=pb21_85.pdf&URI=Bulletins/pb21_85.pdf

Services	Definition of Services and What It May/May Not Include	Target Group	Eligibility Criteria	Reimbursement

	• Assisting in arranging for and supporting the details of the move.
	• Assistance with transition from homelessness, inpatient, residential treatment, jail and/or other institutions, including assistance with discharge planning and planning for returning to community life by assisting with moving, timely access to services, medication and benefits, returning to or finding a place to live, collaboration with discharge planners and other staff to develop and implement effective discharge or transition plans and other assistance as needed during the transition.
	  ◦ Accessing resources and making applications, including access to utilities and essential items and resources to move into a new home.
	  ◦ Developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.
	  ◦ Therapeutic, rehabilitative and skills development.
	  ◦ Income, employment, education and vocational activities.
	  ◦ Behavioral/medical health coordination.
	
	Preauthorized for up to 180 days at a monthly rate. Authorization beyond the initial preauthorization is tailored based on medical necessity.
	
	Housing and Tenancy-Sustaining Services support participants in maintaining tenancy once housing is secured. Services include, but aren't limited to:
	• Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment and other lease violations.
	• Education and training on the roles, rights, and responsibilities of the tenant and landlord.
	• Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy.
	• Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action.
	• Advocacy and linkage with community resources to prevent eviction when housing is, or may potentially become, jeopardized.
	• Assistance with the housing recertification process.
	• Coordinating with the tenant to review, update, and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.
	• Continuing training in being a good tenant and lease compliance, including ongoing support with activities related to household management.
	
	Also, this includes support focused on helping participants to live with maximum independence in the community and in their own home, including activities to improve socialization, self-advocacy, and the development of natural supports. The specific activities covered include:
	1. Therapeutic rehabilitative skills development.
	2. Income, employment, education and vocational activities.
	
	Also includes support with accessing and using medical, dental, substance use disorder and/or behavioral health treatment; supports participants to manage their complex health needs/conditions through health coaching, wellness education, medication education; and helping participants to overcome barriers to treatment adherence.
		The following steps are followed to target individuals who are most likely to benefit from the services included in CHESS and for whom the services are most likely to result in the reduction of preventable Medicaid expenditures:
		1. Risk scores and costs associated with inpatient stays are calculated for each of the adults who have been identified as homeless at any time during the measurement period, which includes any method of identifying the individual as meeting the target criteria of homelessness described above.
		2. Risk scores and costs associated with inpatient stays are calculated for Medicaid adults without any evidence of homelessness during the measurement period. Evidence of homelessness is identified utilizing the HUD definition and documented using any of the following: the Homeless Management Information System, any use of shelter, DSS address or literal use of the term "homeless" in the address field in Medicaid eligibility data, or the use of the ICD codes for homelessness on any claim submitted by any Medicaid provider during the measurement period.
		3. The average inpatient cost by risk score is then calculated for the nonhomeless population.
		4. The inpatient costs of homeless individuals by risk score ("observed") are then compared to the average inpatient cost of nonhomeless individuals ("expected") with the same risk score.
		5. The difference in cost for each of the homeless individuals is the estimate of possible savings that could be achieved by providing stable housing as well as supportive services to the homeless population.
		6. CHESS will target those people where the "observed" inpatient cost over a 12-month period is greater than the "expected" inpatient cost.
		7. Identification methodology is further adjusted to account for and thereby prevent any racial and ethnic disparity.
			activities of daily living, including, but not limited to:
			• Bathing
			• Dressing
			• Eating
			• Toileting
			• Transferring
			• Meal preparation
			• Shopping
			• Medication management
			• Healthcare coordination
			• Transportation
			• Housework
			• Managing finances
			• Maintaining housing stability
			• Behavioral health management	

Services	Definition of Services and What It May/May Not Include	Target Group	Eligibility Criteria	Reimbursement
	Preauthorized for up to 365 days at a monthly rate. Authorization beyond the initial preauthorization is tailored based on medical necessity. Providers must provide services monthly and must provide the service through direct face-to-face contact with the participant at least one time every three months. **Transportation** Mileage is payable under this service when the provider uses their own vehicle. Transportation includes mileage reimbursement and/or bus passes for transportation related to goals defined in the PCRP, including: • Travel to appointments with a participant and/or transportation to access community services, activities and supports. • Assistance with transition, including transportation as needed, to move back to the community if hospitalized or in residential treatment. • Transporting a participant or providing bus passes to support the participant to be self-employed, work from home, or perform work in a community-based setting. Monthly bus passes may also be provided but may not duplicate a bus pass provided under the Medicaid non-emergency medical transportation (NEMT) benefit. Transportation is limited to $1,000 per year. This may be exceeded based on medical necessity.			

Hawaii

State	Hawaii[4]	**Authority**	1115
Title of Benefit and Year Benefit Began	Community Integration Services (CIS)—2022.[5] The State also has a Community Transition Services (CTS) Pilot Program within the broader CIS services. CIS services would generally be approvable under 1915(i) while the CTS services would not.		
Entity Determining Eligibility	MCO		
Projected Number Served	Not available		
Third-Party Administrator Involved in Billing?	The MCOs are responsible; services are not provided via Fee for Service (FFS)		

Services	Definition of Services and What it May/May Not Include	Target Group	Eligibility Criteria	Reimbursement

• Pre-tenancy supports (CIS)
• Tenancy-sustaining services (CIS)
• Transitional case management services (CTS)
• Housing quality and safety improvement services (CTS)
• Legal assistance (CTS)
Securing house payments (CTS)
	(CIS) Pre-Tenancy Supports
	• Conducting a functional needs assessment identifying the beneficiary's preferences related to housing (e.g., type, location, living alone or with someone else, identifying a roommate, accommodations needed, or other important preferences) and needs for support to maintain community integration (including what type of setting works best for the individual), providing assistance in budgeting for housing and living expenses.
	• Assisting beneficiaries with connecting to social services to help with finding and applying for housing necessary to support the individual in meeting their medical care needs.
	• Developing an individualized plan based upon the functional needs assessment as part of the overall person-centered plan. Identifying and establishing short- and long-term measurable goals and establishing how goals will be achieved and how concerns will be addressed.
	• Participating in person-centered plan meetings at redetermination and/or revision plan meetings, as needed.
	• Providing supports and interventions per the person-centered plan.
	
	(CIS) Tenancy-Sustaining Services
	• Service planning support and participating in person-centered plan meetings at redetermination and/or revision plan meetings, as needed.
	• Coordinating and linking the recipient to services and service providers including primary care and health homes; substance use treatment providers; mental health providers; medical, vision, nutritional and dental providers; vocational, education, employment and volunteer supports; hospitals and emergency rooms; probation and parole; crisis services; end-of-life planning; and other support groups and natural supports.
	• Entitlement assistance including assisting beneficiaries in obtaining documentation, navigating and monitoring application process, and coordinating with the entitlement agency.
	• Assistance in accessing supports to preserve the most independent living such as individual and family counseling, support groups, and natural supports.
	• Providing supports to assist the beneficiary in the development of independent living skills, such as skills coaching, financial counseling, and anger management.
	• Providing supports to assist the beneficiary in communicating with the landlord and/or property manager regarding the participant's disability (if authorized and
		Individual meets at least one of the following health needs–based criteria and is expected to benefit from CIS:
		• Individual assessed to have a behavioral health need which is defined as one or more of the following criteria:
		  • Mental health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support) resulting from the presence of a serious mental illness; and/or
		  • Substance use need, where an assessment using American Society of Addiction Medicine (ASAM) criteria indicates that the individual meets at least ASAM level 2.1.
		  • Individual assessed to have a complex physical health need, which is defined as a long-continuing or indefinite physical condition requiring improvement, stabilization, or prevention of deterioration of functioning (including the ability to live independently without support).
		
		The individual must have at least one of the following risk factors:
		1. Homelessness, defined as lacking a fixed, regular, and adequate nighttime residence, meaning:
		  • Has a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground.
		  • Living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low-income individuals).
		2. At risk of homelessness, defined as an individual who shall lose their primary nighttime residence:
		  • There is notification in writing that their residence will be lost within 21 days of the date of application for assistance.
		  • No subsequent residence has been identified; and
		  • Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to or living in a place not meant for human habitation, a safe haven, or an emergency shelter; or
		  • History of frequent and/or lengthy stays in a nursing facility
		  • Frequent is defined as more than one contact in the past 12 months.
		
		Lengthy is defined as 60 or more consecutive days within an institutional care facility.
			Services are provided solely through MCOs. Services are included in the MCO capitation.

[4] Center for Medicare and Medicaid Services. October 14, 2020. "QUEST Integration Medicaid Section 1115 Demonstration." https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/hi/hi-quest-expanded-ca.pdf

[5] Hawaii Interagency Council on Homelessness. Policy Brief May 25, 2022 "Expanding Housing Supports through Medicaid Community Integration Services." https://homelessness.hawaii.gov/wp-content/uploads/2022/05/Policy-Brief-Medicaid-CIS-FINAL-052522.pdf

Services	Definition of Services and What it May/May Not Include	Target Group	Eligibility Criteria	Reimbursement
	appropriate), detailing accommodations needed, and addressing components of emergency procedures involving the landlord and/or property manager. • Coordinating with the beneficiary to review, update, and modify housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers. • Connecting the beneficiary to training and resources that will assist the individual in being a good tenant and lease compliance, including ongoing support with activities related to household management. **(CTS) Transitional Case Management Services** • Services that will assist the individual with moving into stable housing, including assisting the individual in arranging the move, assessing the unit's and individual's readiness for move-in, assisting the individual (excluding financial assistance) in obtaining furniture and commodities. • This service is furnished only to the extent it is reasonable and necessary as clearly identified through an enrollee's care plan and the enrollee is unable to meet such expense or when the services cannot be obtained from other sources. • Includes funding related to one-time utility set-up and moving costs, provided that such funding is not available through any other program. **(CTS) Housing Quality and Safety Improvement Services** • Repairs or remediation for issues such as mold or pest infestation if repair or remediation provides a cost-effective method of addressing the occupant's health condition, as documented by a health care professional, and remediation is not covered under any other program. The service is furnished only to the extent it is reasonable and necessary as clearly identified through an enrollee's care plan and the enrollee is unable to meet such expense or when the services cannot be obtained from other sources. • Includes modifications to improve accessibility of housing (e.g., ramps, rails) and safety (e.g., grab bars in bathtubs) when necessary to ensure occupant's health and modification is not covered under any other provision such as the ADA. **(CTS) Legal Assistance** • Assisting the individual connect to expert community resources to address legal issues impacting housing, thereby adversely impacting health, such as assistance with breaking a lease due to unhealthy living conditions. The service does not include legal representation or payment for legal representation. **(CTS) Securing House Payments** • A one-time payment for security deposit and/or first month's rent provided that such funding is not available through any other program. Payment may only be made once for each enrollee during the life of the demonstration, except for state determined. • Extraordinary circumstances, such as a natural disaster. The service is furnished only to the extent it is reasonable and necessary as clearly identified through beneficiary's individualized care and the beneficiary is unable to meet such expense or when the services cannot be obtained from other sources.			

North Carolina

State	North Carolina[6]	**Authority**	1115
Title of Benefit and Year Benefit Began	Healthy Opportunities Pilots (HOPs)–approved to begin late 2019; delayed implementation until March 2022		
Entity Determining Eligibility	HOP Administrator care managers.[7,8] HOP administrators vary by region.		
Projected Number Served	Number served for all HOP services (which includes more than just housing supports) is 20,167 from implementation in early 2022 through June 2024.[9]		
Third-Party Administrator Involved in Billing?	Yes; HOP administrators vary by region with responsibilities including: Managing a capped allocation of funding to spend on Pilot services, determining which members meet Pilot eligibility criteria and authorizing Pilot services, paying non-traditional providers, Health Service Organizations (HSOs) with Pilot funds.		

Services	Definition of Services and What it May/May Not Include	Target Group / Eligibility Criteria	Reimbursement

• Housing navigation, support, and sustaining services
• Inspection for housing safety and quality
• Housing move-in support
• Essential utility set-up
• Home remediation services
• Home accessibility and safety modifications
• Healthy home goods
• One-time payment for security deposit and first month's rent
• Short-term post-hospitalization housing
	Housing Navigation, Support and Sustaining Services
	Provision of one-to-one case management and/or educational services to prepare an enrollee for stable, long-term housing (e.g., identifying housing preferences and developing a housing support plan), and to support an enrollee in maintaining stable, long-term housing (e.g., development of independent living skills, ongoing monitoring and updating of housing support plan). Activities may include:
	Housing Navigation and Support
	• Assisting the enrollee to identify housing preferences and needs.
	• Connecting the enrollee to social services to help with finding housing necessary to support meeting medical care needs.
	• Assisting the enrollee to select adequate housing and complete a housing application, including by: obtaining necessary personal documentation required for housing applications or programs; or supporting with background checks and other required paperwork associated with a housing application.
	• Assisting the enrollee to develop a housing support and crisis plan to support living independently in their own home.
	• Assisting the enrollee to develop a housing stability plan and support the follow through and achievement of the goals defined in the plan.
	• Assisting to complete reasonable accommodation requests.
	• Identifying vendor(s) for and coordinating housing inspection, housing move- in, remediation and accessibility services.
	• Assisting with budgeting and providing financial counseling for housing/living expenses (including coordination of payment for first month's rent and short-term post hospitalization rental payments).
	• Providing financial literacy education and on budget basics and locating community-based consumer credit counseling bureaus.
	• Coordinating other HOP housing-related services, including:
	  ◦ Coordinating transportation for enrollees to housing-related services necessary to obtain housing (e.g., apartment/home visits).
	  ◦ Coordinating the enrollee's move into stable housing including by assisting with logistics of the move (e.g., arranging for moving company or truck rental), utility set-up and reinstatement, and obtaining furniture/commodities to support stable housing.
	  ◦ Referral to legal support to address needs related to finding and maintaining stable housing.
		Individuals meet at least one needs-based criteria **and** at least one risk factor.
		Needs-Based Criteria for Adults 21 and Older
		• Two or more chronic conditions. These include: BMI over 25, blindness, chronic cardiovascular disease, chronic pulmonary disease, congenital anomalies, chronic disease of the alimentary system, substance use disorder, chronic endocrine, cognitive conditions, chronic musculoskeletal conditions, chronic mental illness, chronic neurological disease, chronic infectious disease, cancer, autoimmune disorders, chronic liver disease, chronic renal failure, intellectual or developmental disability (I/DD), and traumatic brain injury (TBI).
		• Meets the clinical eligibility criteria for Tailored Care Management, North Carolina's Health Home benefit.
		• Repeated incidents of emergency department use (defined as more than four visits per year) or hospital admissions.
		• Former placement in North Carolina's foster care or kinship placement system.
		• Previously experienced three or more categories of adverse childhood experiences (ACEs).
		North Carolina has different needs-based criteria for HOPs for pregnant women and children that have not been included here as not as applicable specifically to pilot services specific to housing.
		Risk Factors
		• Homelessness or housing insecurity: Homelessness, as defined in 42 CFR § 254b(h)(5)(A), or housing insecurity, as defined based on the principles in the questions used to establish housing insecurity in the Accountable Health Communities Health-Related Screening Tool or the North Carolina Social Determinants of Health (SDOH) screening tool.
		• Food insecurity:
		  ◦ As defined by the U.S. Department of Agriculture commissioned report on food insecurity in America:
			Housing Navigation, Support and Sustaining Services is reimbursed PMPM. The current PMPM is $433.62.[10]
			Inspection for Housing Safety and Quality is a Cost-Based Reimbursement up to a cap of $294.17 per inspection.
			Housing Move-In Support is a Cost-Based Reimbursement up to the following caps:
			• 1 BR: Up to $1,159.00 per month
			• 2 BR: Up to $1,335.50 per month
			• 3 BR: Up to $1,453.17 per month
			• 4 BR: Up to $1,512.00 per month
			• 5+ BR: Up to $1,570.83 per month
			Essential Utility Set-Up is a Cost-Based Reimbursement up to the following caps:
			• Up to $588.33 for utility deposits, and
			• Up to $588.33 for reinstatement utility payment, and
			• Up to $588.33 for utility arrears.
			Home Remediation Services is a Cost-Based Reimbursement up to $5,883.33 per year.

[6] Centers for Medicare and Medicaid Services. November 29, 2023. "North Carolina Medicaid Reform Demonstration." https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nc-medicaid-reform-demo-cms-aprvl-11292023.pdf

[7] State of North Carolina Department of Health and Human Services. July 2022. "Fact Sheet: Healthy Opportunities Pilots" https://www.ncdhhs.gov/healthy-opportunities-pilots-fact-sheet/download?attachment#:~:text=ELIGIBILITY%20CRITERIA&text=To%20be%20eligible%20for%20and,delivered%20by%20human%20services%20organizations

[8] State of North Carolina Department of Health and Human Services. July, 5, 2024. "Healthy Opportunities Pilots." https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/healthy-opportunities-pilots#HOPAdministrators-5218

[9] State of North Carolina Department of Health and Human Services. July 29, 2024. "Healthy Opportunities Pilots at Work." https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/healthy-opportunities-pilots/healthy-opportunities-pilots-work

[10] State of North Carolina Department of Health and Human Services. July 1, 2024. "Updated Healthy Opportunities Pilots Fee Schedule." https://www.ncdhhs.gov/healthy-opportunities-pilot-fee-schedule-and-service-definitions/open

Services	Definition of Services and What it May/May Not Include	Target Group	Eligibility Criteria	Reimbursement

	Tenancy-Sustaining Services
	• Assisting the enrollee in revising housing support/crisis plan.
	• Assisting the enrollee to develop a housing stability plan and support the follow through and achievement of the goals defined in the plan, including assistance applying to related programs to ensure safe and stable housing (e.g., Social Security Income and weatherization programs), or assuring assistance is received from the enrollee's Medicaid care manager.
	• Assisting the enrollee with completing additional or new reasonable accommodation requests.
	• Supporting the enrollee in the development of independent living skills.
	• Connecting the enrollee to education/training on tenants' and landlords' role, rights and responsibilities.
	• Assisting the enrollee in reducing risk of eviction with conflict resolution skills.
	• Coordinating other Pilot housing-related services, including:
	  ◦ Assisting to complete annual or interim housing re- certifications.
	  ◦ Coordinating transportation for enrollees to housing-related services necessary to sustain housing.
	  ◦ Referral to legal support to address needs related to finding and maintaining stable housing.
	
	Inspection for Housing Safety and Quality
	A housing safety and quality inspection by a certified professional includes assessment of potential home-based health and safety risks to ensure the living environment is not adversely affecting occupants' health and safety. Inspections may assess the habitability and/or environmental safety of an enrollee's current or future dwelling.
	
	Inspections may include:
	• Inspection of building interior and living spaces for the following:
	  ◦ Adequate space for individual/family moving in.
	  ◦ Suitable indoor air quality and ventilation.
	  ◦ Adequate and safe water supply.
	  ◦ Sanitary facilities, including kitchen, bathroom and living spaces.
	  ◦ Adequate electricity and thermal environment and absence of electrical hazards.
	  ◦ Potential lead exposure.
	  ◦ Conditions that may affect health (e.g., presence of chemical irritants, dust, mold, pests).
	  ◦ Conditions that may affect safety.
	• Inspection of building exterior and neighborhood for the following:
	  ◦ Suitable neighborhood safety and building security.
	  ◦ Condition of building foundation and exterior, including building accessibility; and
	  ◦ Condition of equipment for heating, cooling/ventilation and plumbing.
	
	Findings must be communicated to the care or case manager working with the enrollee to ensure referrals to appropriate organizations for additional home remediation and/or modifications, if necessary. The service can cover Housing Quality Standards (HQS) inspections upon move-in to a new residence, or other inspections to identify sub-standard housing that impacts an enrollee's health and safety. It also covers failed inspections and re-inspections.
	
	Each housing inspection does not need to include all activities listed in this service description, and service providers should only execute the necessary components of a housing safety and quality inspection as required based on an enrollee's circumstances.
	
	Housing Move-in Support Services are nonrecurring set-up expenses. Allowable expenses include but are not limited to the following:
			◦ Low food security: Reports of reduced quality, variety, or desirability of diet. Little or no indication of reduced food intake.
			◦ Very low food security: Reports of multiple indications of disrupted eating patterns and reduced food intake.
			• Or food insecure as defined based on the principles in the questions used to establish food insecurity in the North Carolina Social Determinants of Health (SDOH) screening tool.
			• Transportation insecurity defined based on the principles in the questions used to establish transportation insecurities in the Accountable Health Communities Health-Related Screening Tool or the North Carolina SDOH screening tool.
			• At risk of, witnessing, or experiencing interpersonal violence defined based on the principles in the questions used to establish interpersonal violence in the Accountable Health Communities Health-Related Screening Tool or the North Carolina SDOH screening tool.
				Home Accessibility and Safety Modifications is a cost-based reimbursement up to $13,000 per lifetime of waiver demonstration.
				
				Healthy Home Goods is a cost-based reimbursement up to a cap of $2,941.66 per year.
				
				One-Time Payment for Security Deposit and First Month's Rent is a cost-based reimbursement up to the following caps:
				• First month's rent: Up to 115 percent fair market rent (FMR) (based on home size)
				• Security deposit: Up to 115 percent FMR (based on home size), doubled
				
				Short-Term Post Hospitalization Housing is a cost-based reimbursement up to the following caps:
				• First month's rent: Up to 115 percent FMR (based on home size)
				• Security deposit: Up to 115 percent FMR (based on home size), doubled

Services	Definition of Services and What it May/May Not Include	Target Group	Eligibility Criteria	Reimbursement

	• Housing application fees.
	• Moving expenses required to occupy and utilize the housing (e.g., moving service to transport an individual's belongings from current location to new housing/apartment unit, delivery of furniture, etc.).
	• Discrete goods to support an enrollee's transition to stable housing as part of this service. These may include, for example:
	  ◦ Essential furnishings (e.g., mattresses and beds, dressers, dining table and chairs).
	  ◦ Bedding.
	  ◦ Basic kitchen utensils and dishes.
	  ◦ Bathroom supplies (e.g., shower curtains and towels).
	  ◦ Cribs.
	  ◦ Cleaning supplies.
	
	This service shall not cover used mattresses, cloth, upholstered furniture, or other used goods that may pose a health risk to enrollees.
	
	Essential utility set-up is a nonrecurring payment to:
	• Provide nonrefundable, utility set-up costs for utilities essential for habitable housing.
	• Resolve arrears related to unpaid utility bills and cover nonrefundable utility set-up costs to restart the service if it has been discontinued in a HOP enrollee's home, putting the individual at risk of homelessness or otherwise adversely impacting their health (e.g., in cases when medication must be stored in a refrigerator).
	
	This may be used in association with essential home utilities that have been discontinued (e.g., initial payments to activate heating, electricity, water, and gas).
	
	Home remediation services are coordinated and furnished to eliminate known home-based health and safety risks to ensure living environment is not adversely affecting occupants' health and safety. Home remediation services may include for example pest eradication, carpet or mold removal, installation of washable curtains or synthetic blinds to prevent allergens, or lead abatement. The cost associated with coordinating service delivery is included in the rate.
	
	Home accessibility and safety modifications are coordinated and furnished to eliminate known home-based health and safety risks to ensure the living environment is not adversely affecting occupants' health and safety. Home accessibility modifications are adjustments to homes that need to be made to allow for enrollee mobility, enable independent and safe living and accommodate medical equipment and supplies.
	
	Home modifications should improve the accessibility and safety of housing (e.g., installation of entrance ramps, handheld shower controls, non-slip surfaces, grab bars in bathtubs, installation of locks and/or other security measures, and reparation of cracks in floor). The cost associated with coordinating service delivery is included in the rate.
	
	Healthy home goods are furnished to eliminate known home-based health and safety risks to ensure the living environment is not adversely affecting occupants' health and safety. Home-related goods that may be covered include, for example, discrete items related to reducing environmental triggers in the home (e.g., a "Breathe Easy at Home Kit" with EPA-vacuum, air filter, green cleaning supplies, hypoallergenic mattress or pillow covers and non-toxic pest control supplies).
	
	Healthy home goods do not alter the physical structure of an enrollee's housing unit. The cost associated with coordinating service delivery is included in the rate.			

Services	Definition of Services and What it May/May Not Include	Target Group	Eligibility Criteria	Reimbursement
	One-time payment for security deposit and first month's rent is provision of a one-time payment for an enrollee's security deposit and first month's rent to secure affordable and safe housing that meets the enrollee's needs. All units that enrollees move into through this service must: • Pass an HQS inspection • Meet fair market rent and reasonableness check • Meet a debarment check For homeless enrollees, all services provided must align with a Housing First approach to increase access to housing, maximize housing stability and prevent returns to homelessness. **Short-term post-hospitalization housing** is post-hospitalization housing for a short-term period, not to exceed six months of service in a 12-month period, due to individual's imminent homelessness at discharge from inpatient hospitalization. Housing should provide enrollees with a safe space to recuperate and perform activities of daily living while receiving ongoing medical care as needed and will be limited to housing in a private or shared housing unit. The setting should promote independent living and transition to a permanent housing solution. Services may not be provided in a congregate setting, as defined by the state. Allowable units for short-term post-hospitalization housing must provide the following for enrollees: • Access to a clean, healthy environment that allows enrollees to perform activities of daily living. • Access to a private or semiprivate independent room with a personal bed for the entire day. • Ability to receive onsite or easily accessible medical and case management services, as needed. For homeless enrollees, all services provided must align with a Housing First approach to increase access to housing, maximize housing stability and prevent returns to homelessness.			

Washington, D.C.

State	Washington DC [11]	**Authority**	1915(i)
Title of Benefit and Year Benefit Began	Housing Supportive Services (HSS) Benefit—2022		
Entity Determining Eligibility	District of Columbia Department of Human Services (DC DHS). DC DHS operates the HCBS benefit for DC, while Department of Health Care Finance (DHCF) is the Medicaid agency.		
Projected Number Served	**Year one** (April 2022–March 2023): 7,000		
Third-Party Administrator Involved in Billing?	No[12]		

Services	Definition of Services and What it May/May Not Include	Target Group	Eligibility Criteria	Reimbursement
• Housing stabilization • Housing navigation	**Housing stabilization** helps a participant sustain living in their own housing in the community. Services include assisting the participant: • Identify and build on the participant's strengths that can help them maintain housing in the community. • In early identification and intervention for behaviors that may jeopardize housing. • In education and training on the roles, rights and responsibilities of the tenant and landlord. • Develop and maintain key relationships with landlords with a goal of fostering successful tenancy. • Resolve disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action. • Develop a household budget and map available community resources (e.g., food, toiletries, household supplies, transportation assistance, etc.) to help ensure the participant's needs are met. • Connect to all benefits for which the participant's eligible (e.g., SNAP benefits, Veterans Affairs benefits, etc.), and assisting the participant in obtaining benefits as appropriate. • Identify and leverage natural community supports (e.g., family, friends, recreational activities, support groups, etc.). • Learn independent living skills (e.g., cooking, housekeeping, basic finances, shopping, etc.). • Connect with employment, education, volunteering, and/or other community programming and resources (e.g., rec centers, libraries, etc.) to help address social isolation. • With the housing recertification process. • Review, update and modify the participant's housing support and crisis plan on a regular basis to reflect needs and address existing or recurring housing retention barriers. • By advocating for and linking the participant with community resources to prevent eviction when housing is or may become jeopardized. • Continue training on good tenancy and lease compliance, including ongoing support with activities related to household management. • Connect to somatic health, mental health, and substance use services. • By providing support with continuing receipt of health, mental health, and substance use services, including:	1. 18 years of age and older; and 2. Have a documented disability or disabling condition, as defined below: • Disability means the term as defined at 42 USC § 416(i). • Disabling condition means an injury, substance use disorder, mental health condition, or illness, as diagnosed by a qualified health professional, that is expected to cause an extended or long-term incapacitation but does not meet the definition of disability in subsection (2)(i) above.	1. Requires assistance with achieving and maintaining housing as a result of a disability or disabling condition, as indicated by a need for assistance with at least one of the following: • Mobility. • Decision-making. • Maintaining healthy social relationships. • Assistance with at least one basic need such as self-care, money management, bathing, changing clothes, toileting, getting food or preparing meals. • Managing challenging behaviors. AND • is experiencing housing instability as evidenced by one of the following risk factors: • Is chronically homeless - an individual is considered chronically homeless if they are living in a place not meant for human habitation or a shelter, have been continuously homeless for at least one year or on at least four separate occasions in the last three years, and can be diagnosed with one or more health conditions that increase the risk of chronic homelessness (e.g., substance use disorders, serious mental illnesses, etc.). • Is at risk of chronic homelessness—an individual is considered at risk of chronic homelessness if they are living in a place not meant for human habitation or a shelter, have been continuously homeless for less than one year and less than four separate occasions in the last three years, lack sufficient resources and support networks to assist them in obtaining permanent housing, and can be diagnosed with one or more health conditions that increase the risk of chronic homelessness. • Has a history of chronic homelessness. An individual is considered to have a history of chronic homelessness if they are currently housed, previously met the chronically homeless criteria, can be diagnosed with one or more health conditions that increase the risk of chronic homelessness, and is at risk of returning to homelessness without HSS.	Reimbursement is a single PMPM rate that encompasses all Housing Stabilization Services and Housing Navigation Services provided to a participant within a month. An agency must provide Housing Stabilization Services and/or Housing Navigation Services a minimum of two times within a month to be eligible for a PMPM payment. 2024 PMPM Rate per fee schedule is $785.72.

[11] Center for Medicare and Medicaid Services. March 25, 2022. "State Plan Amendment (SPA) #: 21-0015." https://www.medicaid.gov/medicaid/spa/downloads/DC-21-0015.pdf

[12] Corporation for Supportive Housing. "Welcome to the Washington, DC Medicaid Academy." PowerPoint Presentation. https://dhs.dc.gov/sites/default/files/dc/sites/dhs/page_content/attachments/Session%20%235B%20Billing%20_0.pdf

Services	Definition of Services and What it May/May Not Include	Target Group	Eligibility Criteria	Reimbursement
	◦ Assistance with scheduling appointments, writing directions, scheduling transportation, etc. ◦ Follow up post appointment to ensure participant understands their services and when their next appointments are scheduled. • Train in motivational interviewing and harm reduction techniques. • In housing re-location. Requires minimum one face-to-face and one other contact per month. Cannot be provided concurrently with 1915(i) housing navigation services (below). **Housing navigation services** help a participant plan for, find, and move to housing of their own in the community. Services include assisting the participant: • Obtain key documents needed for the housing application process. • With the housing application process, including following up with key partners (landlord, government agencies) to ensure receipt and processing of documents. • With the housing search process, including helping the participant identify neighborhood and unit needs and preferences, potential barriers (to avoid applying for units for which they will be screened out), helping identify possible units, and assisting to view units). • Identify resources to cover expenses such as security deposit, moving costs, furnishings, adaptive aids, environmental modifications, moving costs and other one-time expenses not covered by Medicaid. • Ensure that the living environment is safe and ready for move-in. • Arrange for and supporting the details of the move. • Develop a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized. • With an application for a home health aide, if needed. Requires services at least once per week with a minimum of two face-to-face each month. CANNOT be provided concurrently with 1915(i) housing navigation services (above); or include: • Deposits. • Food. • Furnishings. • Rent. • Utilities. • Room and board. • Moving expenses. Housing Navigation Services limited to six months from the first interaction. Additional months may be provided subject to prior authorization.			

Washington

State	Washington[13]	Authority	1115
Title of Benefit and Year Benefit Began	Community Support Services (CSS)—2018. This is the specific supportive housing benefit within the Foundational Community Supports (FCS) Program.		
Entity Determining Eligibility	Contracted Third-Party Administrator (TPA). Current contract is with Wellpoint.		
Projected Number Served	Does not appear available by year; however, as of September 2023, 9,410 individuals had enrolled in the CSS portion of FCS since it began in 2018.[14] FCS enrollment paused as of April 2024 due to increased enrollment in 2023 and budgetary limits for 2024 being met.[15] No more than $41,915,000 of the general fund—federal appropriation and $20,310,000 of the general fund-local appropriation may be expended for supported housing and employment services.		
Third-Party Administrator Involved in Billing?	Yes		

Services	Definition of Services and What it May/May Not Include	Target Group	Eligibility Criteria	Reimbursement
• Pre-tenancy supports • Tenancy-sustaining services	**Pre-Tenancy Supports** • Conducting a functional needs assessment identifying the participant's preferences related to housing (e.g., type, location, living alone or with someone else, identifying a roommate, accommodations needed, or other important preferences) and needs for support to maintain community integration (including what type of setting works best for the individual), assistance in budgeting for housing/living expenses, assistance in connecting the individual with social services to assist with filling out applications and submitting appropriate documentation in order to obtain sources of income necessary for community living and establishing credit, and in understanding and meeting obligations of tenancy. • Assisting individuals to connect with social services to help with finding and applying for housing necessary to support the individual in meeting their medical care needs. • Developing an individualized community integration plan based upon the functional needs assessment as part of the overall person-centered plan. Identifying and establishing short- and long-term measurable goals, and establishing how goals will be achieved and how concerns will be addressed. • Participating in person-centered plan meetings at redetermination and/or revision plan meetings, as needed. • Providing supports and interventions per the person-centered plan, including the purchase of pay-as-you-go cell phone devices as a means to access telehealth services for pre-tenancy supports. **Tenancy-Sustaining Services** • Service planning support and participating in person-centered plan meetings at redetermination and/or revision plan meetings, as needed. • Coordinating and linking the recipient to services, including primary care and health homes; substance use treatment providers; mental health providers; medical, vision, nutritional and dental providers; vocational, education, employment, and volunteer supports; hospitals and emergency departments; probation and parole; crisis services; end-of-life planning; and other support groups and natural supports, including the purchase of pay-as-you-go cell phone devices as a means to access telehealth services for pre-tenancy supports.	Medicaid clients aged 16 or older who meet the needs-based criteria.	Individual assessed to have a behavioral health need, which is defined as one or both of the following criteria: • Mental health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support) resulting from the presence of a mental illness; and/or • Substance use need, where an assessment using the ASAM Criteria indicates that the individual meets at least ASAM level 1.0. • Individual assessed to have a need for assistance, demonstrated by the need for: • Assistance with three or more activities of daily living (ADLs) defined in WAC 388-106-0010, one of which may be body care, and/or • Hands-on assistance with one or more ADLs, one of which may be body care. • Individual assessed to have a complex physical health need, which is defined as a long-continuing or indefinite physical condition requiring improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support). AND Individual has at least one of the following risk factors: • Homelessness, defined as living in a place not meant for human habitation, a safe haven, or an emergency shelter, as these terms are understood or defined in 24 CFR 578.3: • For at least 12 months, or • On at least four separate occasions in the last three years, as long as the combined occasions equal at least 12 months. • History of frequent and/or lengthy stays in the settings defined in 24 CFR 578.3, or from, a skilled nursing facility as defined in WAC 388-97-0001. • Frequent is defined as more than one contact in the past 12 months. • Lengthy is defined as 90 or more consecutive days within an institutional care facility. • History of frequent adult residential care stays, where:	Under the 1115, Washington will reimburse a Third-Party Administrator (TPA) for CSS services provided at the CSS rates. The rates shall not exceed the amount expended by the TPA for the direct service costs incurred by the provider. Rates may vary by region and may be developed based on a target cost per CSS service, along with variables such as geographic location, FCS-related travel costs, intensity of services, and duration of services or contracted provider per unit costs.

[13] Centers for Medicare and Medicaid Services. March 27, 2024. "Washington State Medicaid Transformation Project 2.0." https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/wa-medicaid-transformation-dmntrtn-aprvl-hrsn-infrtre-prtcl.pdf

[14] Washington State Health Care Authority. October 2023. "Foundational Community Support FAQ." https://www.hca.wa.gov/assets/program/fact-sheet-foundational-community-supports.pdf

[15] Washington State Health Care Authority. April 2024. "Foundational Community Support FAQ." https://www.provider.wellpoint.com/docs/gpp/WA_WLP_CAID_FCSEnrollPauseWaitlistFAQ.pdf?v=202406202111#:~:text=FCS%20assessments%20have%20a%20five,resubmit%20necessary%20documentation%20for%20reconsideration.

Services	Definition of Services and What it May/May Not Include	Target Group	Eligibility Criteria	Reimbursement
	• Entitlement assistance including assisting individuals in obtaining documentation, navigating and monitoring application process, and coordinating with the entitlement agency. • Assistance in accessing supports to preserve the most independent living such as individual and family counseling, support groups, and natural supports. • Providing supports to assist the individual in the development of independent living skills, such as skills coaching, financial counseling, and anger management. • Providing supports to assist the individual in communicating with the landlord and/or property manager regarding the participant's disability (if authorized and appropriate), detailing accommodations needed, and addressing components of emergency procedures involving the landlord and/or property manager. • Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers. • Connecting the individual to training and resources that will assist the individual in being a good tenant and lease compliance, including ongoing support with activities related to household management. .		• Frequent is defined as more than one contact in the past 12 months. • Adult residential care includes residential treatment facilities defined in WAC 246-337-005; adult residential care, enhanced adult residential care, or assisted living facilities defined in WAC 388-110-020, and adult family homes defined in WAC 388-76-10000. • History of frequent turnover of in-home caregivers, where within the last 12 months the individual utilized three or more different in-home caregiver provider agencies, and the current placement is not appropriate for the individual. • A Predictive Risk Intelligence System (PRISM) score of 1.5 or above. The PRISM score uses diagnosis, prescription, age, and gender information from claims and encounter data to create an index of a client's expected future medical expenditures relative to the expected future medical expenditures of a comparison group (disabled Medicaid adults). The algorithm uses risk factor categories developed at University of California–San Diego known as the Chronic Illness and Disability Payment System (CDPS) and Medicaid Rx, deemed by the Society of Actuaries to be effective methods of risk adjustment. The PRISM risk score is updated monthly by the Washington State Department of Social and Health Services' Research and Data Analysis division using the past 15 months of claims, encounter, and demographic data.	

Appendix B: Evaluation of Housing Stabilization Services Payment Structure

HMA performed a high-level evaluation of the payment structure for Housing Stabilization Services (HSS). Please note that there was no available documentation regarding establishing the current payment rate. Should such documentation be made available, elements of this evaluation would require updates to remain an adequate overview.

Adequacy of Payment Rates

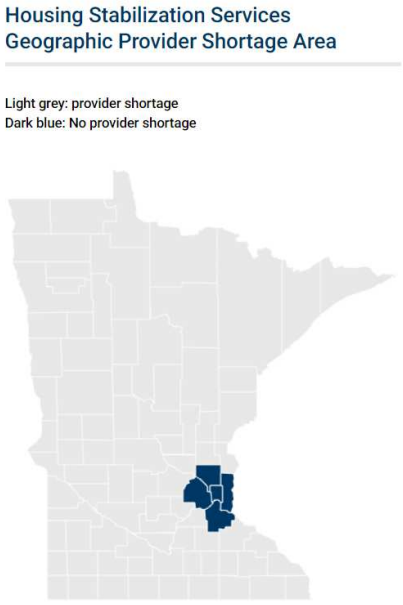
The state plan amendment for HSS does not detail how the payment rates were developed (the Methods and Standards for Establishing Payment Rates section only lists the rates and billing units). It is therefore difficult to determine the reasonableness of the current rates. However, the current rates have been in effect for more than four years (adopted July 1, 2020) so, if the rates were appropriate at the time, they are likely no longer appropriate today, as the consumer price index (which is likely not the best indicator of changes in providers' costs) has increased more than 21 percent since that time.

Rate Design

Considering the structure of the payment rates, please note:

Cost assumptions. As stated above, documentation about how the current payment rates were established was not available, making it difficult to determine the adequacy of these rates. Rates for many other services across Minnesota's Medicaid system are based on detailed methodologies. For example, the Disability Waiver Rate System (DWRS) includes worksheets that detail cost assumptions for individual cost drivers such as direct care staff wage and benefit costs, supervision, and administration. Without this type of detail for HSS, it is unclear whether the rate adequately accounts for the cost of the staff delivering services, their nonbillable time, etc.

Geographic differentiation. Unlike rates in some other programs that have geographic adjustment factors (such as DWRS services), HSS rates are statewide. Since DHS's geographic capacity map shows Housing Stabilization provider shortages outside of the greater Minneapolis-St. Paul area, regionally differentiated rates might be appropriate.



Billing Policies

The billing rules contemplate several issues that influence this type of service, including:

On behalf of activities. The policy indicates that many billable supports may be provided indirectly or on behalf of the individual. This recognizes that much of the work that a provider may perform (such as developing plans, researching options, and identifying resources) may occur without the member being present (although the policy does state that "services are primarily provided as a direct service").

Remote supports. The policy allows for supports to be delivered remotely, recognizing that this type of service does not always need to be delivered face-to-face.

No-shows. The policy prohibits billing for missed appointments, as is typical for Medicaid-funded services. However, there are still costs associated with these no-shows that need to be incorporated into the payment rate for billable time. Without detailed cost assumptions, it is unclear whether these costs have been adequately accounted for.

Billing Units

Housing Consultation services are billed per "session" to develop a housing-focused person-centered plan (and which is typically limited to once per year). Without a judgment on the adequacy of the rate itself, a session (or milestone) rate for Housing Consultation seems appropriate as it is pays for a specific defined activity (plan completion).

Housing Transition and Housing Sustaining services are billed in 15-minute units, which can be appropriate for these types of services. A number of other states pay for similar housing-related services with a 15-minute rate (including Connecticut and North Dakota). Other payment approaches can also be appropriate; for example, some states pay monthly case rates for similar services (including the District of Columbia and New York). Although multiple options may be viable, the best option for Minnesota would depend on considerations such as (but not limited to):

- **Accounting for providers' reasonable costs.** Any payment rate should seek to reflect a provider's reasonable costs, which can be accomplished across various billing units. For example, 15-minutes rates need to account for nonbillable time (such as no-shows) while a monthly rate depends on a reasonable caseload assumption.
- **Differences in service levels.** When there are significant differences in the amount of support that an individual receives, a 15-minute rate ensures providers get paid more when delivering more support. In contrast, a monthly rate can encourage providers to accept only those with the least needs unless there is a no-reject policy or an ability to risk adjust (through tiered rates, for example).
- **Expected duration of service.** If a service is expected to be longer-term, a monthly rate increases the predictability of provider revenue, supporting planning and sustainability.
- **Administrative burden.** A monthly case rate reduces the burden on providers to closely track every activity performed, particularly when there is a significant degree of on behalf of supports.
- **Accountability measures.** With 15-minute rates, providers are paid for what they deliver. With monthly rates, however, payment is less connected to actual supports. Thus, services paid for monthly may require more accountability measures, such as a minimum number of contacts or hours of support.

Opportunities for Outcome-Based Rates

The state could consider outcome-based rates either in lieu of fee for service rates or to complement the existing rates. Exploration of outcome-based payment models would require evaluation of service goals, data collection capabilities, and other administrative considerations.

Appendix C: Housing Stabilization Services (HSS) TA Team: Two-year Report and Recommendations

Commented [SG1]: Corporation for Supportive Housing Report

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Appendix D: Accessing and Maintaining Long-Term Solutions to Homelessness

Commented [SG2]: Hearth Connections Report

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