

Montana | 2019  
**M E D I C A I D**  
SUPPORTIVE HOUSING  
**S E R V I C E S**  
CROSSWALK



### About The Montana Healthcare Foundation

Montana Healthcare Foundation (MHCF), a 501(c)3 private foundation, is dedicated to improving the health and well-being of all Montanans. MHCF contributes to a healthier state by making strategic investments that strengthen public health, support access to quality and affordable health services, conducting evidence-driven research and analysis, and addressing the upstream influences on health and illness. Some Montanans face particularly difficult barriers to health. Health disparities (the higher rates of illness and death that are consistently documented among certain subgroups) are all too common among certain racial and ethnic groups, the social and economic disadvantaged, young children, and older adults. Across all our work, we place an emphasis on reducing health disparities and building healthier Montana communities.

### About CSH

CSH has been the national leader in supportive housing for over 25 years. We have worked in 48 states to help create stable, permanent homes for individuals and families. This housing has transformed the lives of over 200,000 people who once lived in abject poverty, on our streets or in institutions. A nonprofit Community Development Financial Institution (CDFI), CSH has earned a reputation as a highly effective, financially stable organization with strong partnerships across government, community organizations, foundations, and financial institutions. Our loans and grants totaling over \$750MM have been instrumental in developing supportive housing in every corner of the country. Through our resources and knowledge, CSH is advancing innovative solutions that use housing as a platform for services to improve lives, maximize public resources, build healthy communities and break the cycle of intergenerational poverty. Visit us at [csh.org](http://csh.org) to learn more.

### Acknowledgements

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## EXECUTIVE SUMMARY

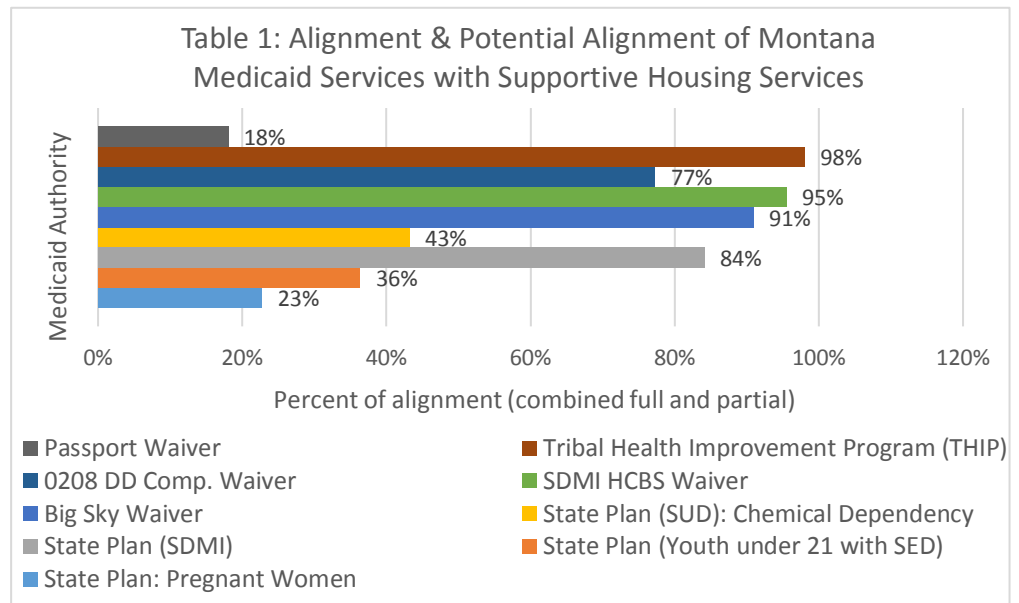
In partnership with the Montana Healthcare Foundation (MHCF), CSH conducted a Montana Medicaid Supportive Housing Services Crosswalk (Crosswalk). Recognizing the positive impacts supportive housing can have on individuals’ health and well-being, housing stability, and healthcare utilization, the Crosswalk examines the extent to which supportive housing services align with existing benefits covered by Montana’s Medicaid program. The full report consists of four parts including a background and definitions section; an overview of key aspects of Montana’s Medicaid program; the Crosswalk results, which provide a summary of key areas of alignment and gaps found in covered services as well as interview results from supportive housing and healthcare provider agencies; and finally, CSH’s recommendations for the steps Montana could consider to maximize Medicaid to reimburse for supportive housing services that enable individuals to live successful, stable lives in their communities. This Executive Summary reviews key findings and recommendations found in the full report.

### Key Findings

Supportive housing services include housing transition services, pre-tenancy and tenancy sustaining services, and care coordination services. The Centers for Medicare and Medicaid Services (CMS) released an important informational bulletin in June 2015, which outlined definitions of pre-tenancy and tenancy support services

that were eligible for Medicaid coverage, should states choose to submit a Medicaid State Plan Amendment or an application for a Home and Community Based Services (HCBS) Waiver program. Using these CMS approved services and definitions, CSH compared these pre-tenancy and tenancy support services and other supportive housing wrap around services to the Montana Medicaid State

Plan, State Plan Amendments and HCBS Waivers. CSH found areas of direct alignment, potential for alignment, and gaps. A complete list of the core services in supportive housing can be found in Appendix A. The full crosswalk of services by Medicaid Authority can be found in Appendix B.



## Alignment

The Montana Medicaid program currently covers many of the services necessary for individuals who benefit most from supportive housing, particularly for those with severe and disabling mental illness (SDMI) who are eligible to receive services under the Medicaid State Plan, HCBS Waivers, and the Tribal Health Improvement Program (T-HIP). Services identified in Table 1 are supportive housing services that align with, or have potential to align with, services currently covered in Montana through the Medicaid State Plan and HCBS Waivers. The Program for Assertive Community Treatment (PACT) is an example of behavioral health services that align well with supportive housing services. The Montana Standards for PACT<sup>1</sup> include “housing” as one of the key areas of treatment planning that all individualized treatment plans must include. The inclusion of housing as a required element in assessment and treatment planning (**required** rather than recommended) helps to ensure that PACT participants will receive support services to address their housing needs and promote housing stability. It is this explicit inclusion and requirement of housing need assessment and support services that distinguishes aligned services from those with potential alignment.

## Potential Alignment

In Montana, many of the CMS defined pre-tenancy and tenancy support services have the potential for alignment. CSH uses the phrase “potential for alignment” when a Medicaid service has room for interpretation to include housing-related supports but state administrative requirements do not explicitly require that the service provider offer this service, such as housing stability and housing support services in needs assessments, individualized service planning, and care coordination. Commonly where potential exists, state leadership has not offered or highlighted training, outcomes measurements and alignment of additional non services resources. Any of these activities would signal to providers the priority that system leadership places on housing stability for program participants. Individual agencies can choose or not choose to address these services needs of the participants they serve and still remain in compliance with program requirements. Table 2 below outlines the supportive housing service and the corresponding Medicaid health services that offers potential for alignment and could support reimbursement if assessing housing stability and potential barriers to remaining successfully in independent housing were routine and required in health assessments. Table 2 outlines the services that have potential for alignment with supportive housing and are occurring formally and informally<sup>2</sup> through behavioral health providers across the State, particularly for individuals with a diagnosis of SDMI.

## What Isn't Covered- Gaps Identified in the Crosswalk and Key Interviews

Some supportive housing services do not align with Montana’s Medicaid State Plan or HCBS Waivers. Four main gaps were identified, and include:

- Gaps in populations served, notably, the lack of alignment for individuals with substance use disorders (SUD); individuals not yet diagnosed with a behavioral health condition but

<sup>1</sup> Montana Standards for Program for Assertive Community Treatment. Page 10. 2011. Retrieved from <https://dphhs.mt.gov/Portals/85/amdd/documents/MTStandardsforPACT.pdf?ver=2017-12-13-142928-393>

<sup>2</sup> In conducting phone interviews, CSH learned that some behavioral health providers formally require staff to ask about housing needs and barriers to remaining housed- and others may do so less formally. This variation in practice and standards led to these services being categorized as having potential for alignment rather than direct alignment.

experiencing homelessness; pregnant women; and high utilizers of health care services experiencing homelessness;

- Gaps in core supportive housing services including: outreach and in-reach, pre-tenancy and housing transition services;
- Gaps in access to waiver services; particularly for individuals experiencing homelessness who are not prioritized for waiver services and unable to be exempt from waitlists;
- Gaps in Medicaid provider understanding of supportive housing; and
- Gaps in supportive housing provider understanding of Medicaid benefits.

<b>Table 2: Supportive Housing Services with Potential for Medicaid Coverage</b>	
<b>Supportive Housing Service</b>	<b>Comparable Medicaid Benefit with Potential for Alignment</b>
Assessment of housing preferences and barriers related to tenancy	Psychosocial Assessment with comprehensive history
Housing Service Plan	Individualized Service Plan Development
Identification of resources to cover moving and start-up expenses	Community Transition Services for people exiting institutions, and referrals to social services and housing under the Passport Waiver
Assistance with move-in arrangements	Community Transition Services for people exiting institutions, PACT services, if medically necessary
Assistance with collecting required documentation (i.e. birth certificate, IDs, credit history)	Community Transition Services for people exiting institutions, PACT services, if medically necessary
Assistance with housing search and housing applications	Community Transition Services for people exiting institutions, PACT services, if medically necessary
Early identification/intervention for behaviors that could jeopardize successful tenancy/housing retention	Psychosocial Assessment with comprehensive history, service plan development, Life Coach services, Residential Habilitation Services and Peer Support Services (SDMI Waiver) <sup>3</sup>
Ensuring housing unit is safe and ready for move-in	PACT, Peer Support Services (SDMI Waiver), Community Transition Services, Specially Trained Attendant (STA) for Big Sky Waiver
Assistance resolving disputes with landlords, property management, and neighbors	PACT, Peer Support Services (SDMI Waiver), Behavioral Support Services (DD Waiver), Life Coach (SDMI Waiver), STA (Big Sky Waiver)
Linkage with community resources to prevent eviction/ sustain tenancy	PACT, Peer Support Services (SDMI Waiver), Personal Supports (DD Waiver), Life Coach (SDMI Waiver), STA (Big Sky Waiver), Referrals (Passport), Targeted Case Management
Ongoing training and support with activities related to household management and tenant habits	Peer Support Services (SDMI Waiver), Personal Supports (DD Waiver), Life Coach (SDMI Waiver), STA (Big Sky Waiver),
Development of housing support crisis plan	Service plan development and crisis plan development

<sup>3</sup> Peer support services are available for individuals receiving services under the SDMI HCBS Waiver. All other peer support services are covered by block grant, outside of Medicaid.

## **Supportive Housing Provider Interviews**

The Crosswalk review also included interviews with supportive housing service providers from across the State, to better understand 1) the range of supportive housing services currently offered by providers, 2) current funding sources for these services and 3) perceptions supportive housing providers have about Medicaid coverage. Interviews identified that: most supportive housing providers are offering a range of the core supportive housing services; many of these supportive housing service providers are Public Housing Authority staff; and most are not Medicaid providers. Supportive housing providers expressed a desire to expand supportive housing services and an understanding that Medicaid may be an avenue for reimbursement. They also shared hesitation regarding Medicaid reimbursement rates and funding at the state level. Providers expressed a need for additional trainings on quality supportive housing services and technical assistance for how they might become Medicaid providers and bill for supportive services using Medicaid.

## **Recommendations**

1. Define and cover supportive housing services using CMS guidelines for a 1915i State Plan Amendment for individuals in priority populations who are experiencing homelessness, exiting institutions, and/or frequent users of crisis systems who need community based supportive housing services to live independently.
2. Examine state program standards that could be more comprehensive in addressing social determinants of health needs of program participants, specifically housing. One example of this includes covering and expand community transition services to include individuals experiencing unsheltered homelessness, individuals exiting shelters and transitional housing. Another process revision could include examining behavioral health program standards to require the inclusion of housing stability and housing needs in assessment and treatment planning for individuals with SDMI, SUD, frequent users of crisis systems, and individuals exiting institutions (similar to how housing assessment is required in the PACT program).
3. Identify flexible resources that are needed for outreach and engagement for individuals in need of supportive housing to ensure that they are assessed and supported in gathering of documents, choice regarding housing options and engagement in services. Agencies will need non-Medicaid funded support to engage persons who are unsheltered and can be difficult to locate consistently.
4. Continue efforts to ensure Tribal communities receive education and support to assist individuals in enrolling in and utilizing Medicaid benefits, particularly the opportunity to use T-HIP to advance supportive housing services through Tier 2 and 3 programming.
5. Build capacity for behavioral health and housing service provider networks by promoting training and technical assistance for 1) supportive housing providers to become Medicaid providers and bill Medicaid and 2) behavioral health and waiver providers to understand the quality standards in supportive housing and service partnerships unique to supportive housing in rural areas.

## INTRODUCTION

In partnership with MHCF and DPHHS, CSH conducted the Medicaid Supportive Housing Services Crosswalk. (Crosswalk). The Crosswalk includes an analysis of supportive housing services alignment with services covered by Medicaid in Montana. This report is intended to provide advocates, healthcare and housing providers the necessary information to advocate for expanded investment in supportive housing through Medicaid coverage.

Supportive housing services include pre-tenancy and housing transition services, housing and tenancy sustaining services, and services that support the coordination of care across housing and healthcare providers. The positive impact supportive housing and its services can have on an individual's use of preventive health care services, management of chronic diseases, and appropriate use of healthcare resources is widely acknowledged by national leaders and supported by evidence-based research.<sup>4</sup> Recognizing the positive health impacts supportive housing can have, the Crosswalk examines the extent to which supportive housing services may be considered eligible for coverage under Montana's Medicaid State Plan and Montana's Medicaid Waivers. The report also provides recommendations for state leaders, health and housing providers, and health advocates working to promote supportive housing and its positive impact on vulnerable individuals across Montana.

### **This report consists of four parts:**

- Part I – Background and definitions for supportive housing and Medicaid
- Part II – Key aspects of Montana's Medicaid State Plan and HCBS Waivers
- Part III – The Crosswalk methodology and findings
- Part IV – CSH's recommendations for the steps Montana can take to maximize Medicaid to reimburse for supportive housing services

<sup>4</sup> Supportive Housing & Healthcare Utilization Outcomes State of the Literature, CSH, 2018.

[https://d155kunxf1aozz.cloudfront.net/wp-content/uploads/2018/07/CSH-supportive-housing-outcomes-healthcare\\_Final.pdf](https://d155kunxf1aozz.cloudfront.net/wp-content/uploads/2018/07/CSH-supportive-housing-outcomes-healthcare_Final.pdf)

## PART I: BACKGROUND AND DEFINITIONS

In Montana, a small yet noteworthy group of residents have critical, unmet housing and healthcare needs. Many of these highly vulnerable individuals are living with multiple chronic health conditions and behavioral health challenges, including SDMI, SUD, and other disabling medical conditions. Most have extremely low incomes and many are unstably housed, homeless, and/or cycling through multiple social service systems and institutions. Despite their frequent use of public systems, such as long-term care facilities, jails, shelters, and hospitals, these individuals are not receiving the level of care they need and therefore are not experiencing improved health outcomes. Instead, they experience expensive and often preventable institutionalization, a lack of access to primary care and a lack of integrated services addressing their co-occurring disorders and co-morbidities. While these residents represent a small percent of the total state population, their healthcare costs constitute a large and disproportionate percent of Montana's Medicaid expenditures, averaging over \$53,000 per person in Medicaid expenses in 2017 alone.<sup>5</sup> It is estimated offering supportive housing for these high cost, high need individuals will result in a 45% cost avoidance in Medicaid claims and the cost avoidance will exceed the cost to provide supportive housing services.

This Crosswalk examines the extent to which the Montana Medicaid State Plan and HCBS Waivers, align with supportive housing services for individuals living with: SDMI; disabling medical conditions; SUD, and intellectual and developmental disabilities. The report also examines how Medicaid in Montana aligns with supportive housing services for American Indian tribal communities, for individuals who are high utilizers of crisis health systems with chronic health conditions, seniors aging in place needing home and community based care, youth with serious emotional disturbance, and pregnant women.

### Supportive Housing Services Crosswalk Definitions

**Supportive housing** combines affordable housing with intensive tenancy support services to help people who face the most complex challenges to live with stability, autonomy and dignity. Research demonstrates that supportive housing provides housing stability, supports community integration, improves health outcomes, and reduces public system costs.<sup>6</sup> Supportive housing is not affordable housing with resident services. It is a specific intervention that provides specialized, housing-based support services with low client-to-staff ratios (generally one-to-fifteen and not more than one-to-twenty-five). Supportive housing units can be in scattered-site rent subsidized apartments, in single-site locations that have been developed or rehabilitated<sup>7</sup>, and in integrated mixed-income buildings with a certain number of units set aside for supportive housing. Supportive housing is a platform for reducing health disparities and providing improvements in health outcomes for the tenants. Specifically studied,

<sup>5</sup> Medicaid Business Case for Supportive Housing. CSH. 2018. De-identified data provided by DPHHS was analyzed after matching 2017 Homeless Management Information System data and 2017 Medicaid claims data.

<sup>6</sup> Supportive Housing & Healthcare Utilization Outcomes State of the Literature, CSH, 2018.

[https://d155kunxf1aozz.cloudfront.net/wp-content/uploads/2018/07/CSH-supportive-housing-outcomes-healthcare\\_Final.pdf](https://d155kunxf1aozz.cloudfront.net/wp-content/uploads/2018/07/CSH-supportive-housing-outcomes-healthcare_Final.pdf)

<sup>7</sup> It is important to note that supportive housing promotes independence and community integration. Supportive housing that utilizes a scattered-site or integrated model can be used to decrease segregation and support community integration for individuals living with disabilities.



health improvements for tenants of supportive housing include a reduction in emergency room (ER) visits, inpatient stays, hospital stays, and ambulance trips. The holistic approach of supportive housing addresses the issues of built environment for someone experiencing homelessness while also providing coordinated services to support the tenant in housing.<sup>8</sup>

The housing in supportive housing is affordable and requires a lease. It is not time-limited or transitional. It is a platform from which tenants can engage in services as they choose, with guidance from housing case managers. The core services in supportive housing are pre-tenancy (outreach, engagement, housing search, application assistance, and move-in assistance) and tenancy-sustaining services (landlord relationship management, tenancy rights and responsibilities education, eviction prevention, crisis intervention, and subsidy program adherence) that help people access and remain in housing. In addition, supportive housing service providers link tenants to clinical primary and behavioral health care services and coordinate with service providers across the community to ensure that supportive housing not only brings about housing stability but supports tenant success in meeting their health and recovery goals. Finally, services such as counseling, peer supports, independent living skills, employment training, end of life planning, and crisis supports are also key ingredients in supportive housing services provided to tenants.

The homelessness response system fully embraces supportive housing as a best practice for ending chronic homelessness, but it does not have the resources to take this intervention to scale. A lack of sustainable services funding often delays the creation of new supportive housing units. Leveraging Medicaid reimbursement for allowable services could allow funders to reallocate their more flexible resources to housing related activities (rental assistance and capital costs) to create more supportive housing units.

**Medicaid** is public health insurance that pays for essential medical and medically related services for individuals with low-incomes. Statutorily, Medicaid insurance cannot pay for room and board. Medicaid's ability to reimburse for services starts with a determination as to whether the services are medically necessary.

**Medicaid State Plan:** States and the federal government jointly finance the Medicaid program. A Medicaid "State Plan" is the contract between an individual state and the federal government with the oversight of CMS. The Medicaid State Plan determines which services are covered and the payment methodology for each service. All state plans require certain mandatory benefits as determined by federal statute. States and CMS can agree to cover additional benefits that are designated optional benefits.<sup>9</sup> For example, the rehabilitative services option is an optional benefit that many states use to cover a broad range of recovery-oriented mental health and SUD services. Medicaid State Plan services are an entitlement; therefore, states must provide services to all individuals who qualify for Medicaid and meet the medical necessity criteria for the service(s). The State is required to submit a **State Plan**

<sup>8</sup> "Permanent Supportive Housing: Addressing homelessness and health disparities?" AM J Public Health, 2013. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3908899/>

<sup>9</sup> For more detail on mandatory and optional Medicaid benefits see <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Medicaid-Benefits.html>

**Amendment** to request permissible program changes, make corrections, or update their Medicaid State Plan with new information. The exception to Medicaid State Plan entitlement is the HCBS 1915(i) State Plan, which will be discussed below under Medicaid HCBS Waivers. While the HCBS 1915(i) is a state plan, it provides waiver provisions similar to HCBS Waiver programs.

**Medicaid HCBS Waivers:** States can waive certain Medicaid program provisions (entitlement) under HCBS waivers. For example, in states facing the opioid epidemic, these states may benefit from creating a waiver on providing supportive housing and case management services to individuals with diagnosed opiate addiction or substance use disorders. HCBS Waivers are commonly known by their federal statute section number. Some have particular applicability to supportive housing services. 1915(c) Waivers and the 1915(i) State Plan Amendment help states target home and community based services for specific populations (seniors, individuals with severe or persistent mental illness, developmental disabilities, children with special health care needs, and individuals living with traumatic brain injuries). These services are designed to serve people in their own homes and communities rather than in institutions. Montana has several 1915(c) Waivers that CSH examined for their alignment with supportive housing services, including the Big Sky Waiver,<sup>10</sup> the 0208 Developmental Disabilities (DD) Comprehensive Waiver,<sup>11</sup> the Severe Disabling Mental Illness (SDMI) Waiver<sup>12</sup>, and the Passport Waiver. The Crosswalk confirms that some of these waivers include benefits needed by those living in supportive housing. In addition, Section 1115 Medicaid demonstration projects allow for states to demonstrate new programs for new services, populations, or payment structures, such as supportive housing tenancy support services for individuals with SUD.

**Medicaid reimbursement** can be delivered in a variety of ways. States can reimburse providers directly for services or contract with managed care organizations (MCOs) to negotiate services and payment structures with providers. Some states reimburse Medicaid providers using fee for service reimbursement, with payments structured using a certain reimbursement methodology per 15 minute unit of service. Others use a per diem, or per month for authorized services to Medicaid members. In some cases, MCOs also deliver services directly. States like Montana, who do not contract with MCOs, establish agency licensing and credentialing requirements and staff qualifications that determine which providers can provide Medicaid services and receive Medicaid reimbursement.

**Indian Health Service/Tribal Health/Urban Indian Health Center:** The Indian Health Service (IHS) is a federal agency within the US Department of Health and Human Services and provides health services to American Indians and their families.<sup>13</sup> The Billings Area Office in Billings, Montana serves as the area headquarters for Montana and Wyoming. Within the Billings Area, the IHS directly provides clinical services in five IHS-operated service units located on five reservations. Under Public Law 93-638, tribes

<sup>10</sup> Montana 1915(c) Big Sky Waiver. <https://dphhs.mt.gov/SLTC/BigSkyWaiverPolMan>

<sup>11</sup> Montana 0208 Developmental Disabilities Comprehensive Waiver. Retrieved from: <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=7994>

<sup>12</sup> Montana SDMI Waiver. Waiver application: <https://dphhs.mt.gov/LinkClick.aspx?fileticket=M74bmOCq1Yg%3d&portalid=85>

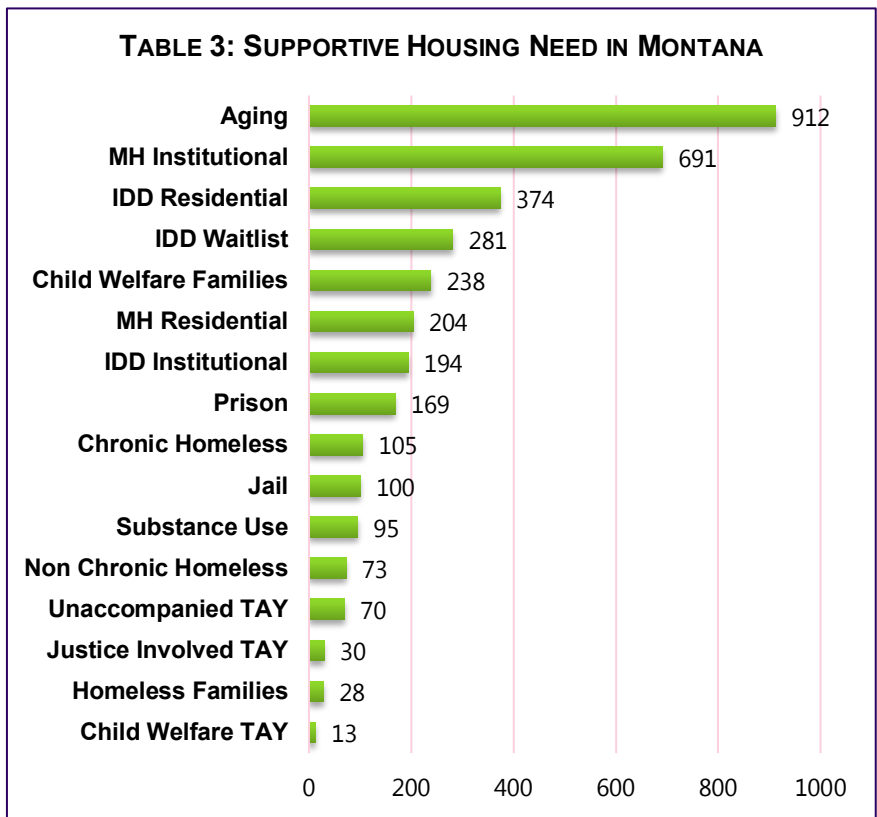
<sup>13</sup> Indian Health Care 101. National Indian Health Board. July 2014. Retrieved from: <https://www.nihb.org/docs/01132015/Indian%20Health%20Care%20101.pdf>

may contract or “compact” with the IHS to provide all or part of the services provided by the IHS. In Montana, the Confederated Salish and Kootenai Tribes and the Chippewa Cree Tribe have compacted to assume responsibility for providing all health care. Tribes on the other five reservations in Montana have contracted with the IHS to provide certain services—the specific services vary, but may include, for example, operating treatment programs for substance use disorders, providing public health services, and providing a range of medical services. Currently all seven tribal health departments in Montana have FQHC status. Finally, there are five urban Indian health centers in Montana, each of which is operated as a nonprofit and funded through a mix of IHS and other grants, and revenue from third party reimbursement.

### Supportive Housing Need in Montana

To better understand the supportive housing need across the United States, CSH staff used publicly available state and local data, to predict the need across a variety of subpopulations in each state.<sup>14</sup> It is predicted that Montana will need 3,577 units of supportive housing to meet the housing and service needs of vulnerable Montanans. Table 3 highlights the supportive housing need in Montana (number of units needed) by subpopulation.

Older adults, individuals with mental health disorders exiting institutional care, individuals with intellectual and development disabilities (IDD), and families involved in the child welfare system are the subpopulation groups needing the largest numbers of units of supportive housing in Montana. Smaller groups also needing the intensive services and affordable housing that supportive housing provides are individuals experiencing chronic homelessness, persons exiting prison and jails, individuals with SUD experiencing homelessness (non-chronic), transition-aged youth (TAY), and families.<sup>15</sup>



Supportive housing is an evidence-based practice recognized by the Substance Abuse and Mental Health Services Administration (SAMHSA) because supportive housing builds a foundation for recovery, improves the integration of behavioral and physical health care, and promotes the collaboration

<sup>14</sup> CSH Supportive Housing Needs in the United States. <https://www.csh.org/supportive-housing-101/data/>

<sup>15</sup> Find detailed data reports on the supportive housing need for each population, total figures, and research references and citations at <https://www.csh.org/supportive-housing-101/data/>

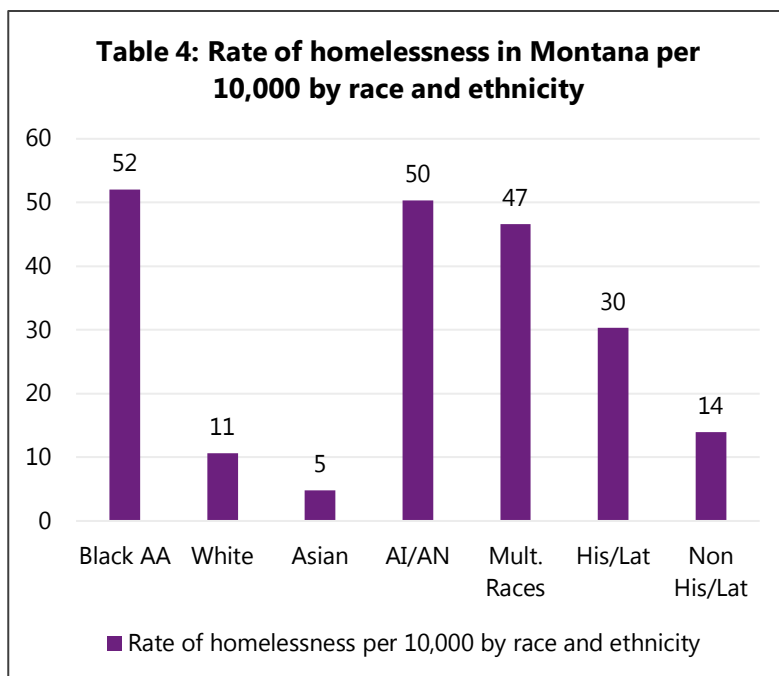
between treatment providers and homeless system providers. This integration can be accomplished through a HCBS 1915i State Plan Amendment that covers supportive housing services for individuals experiencing homelessness, aging in place, exiting institutions, and cycling in and out of emergency and crisis service systems (jails, prisons, shelters, hospitals, and detox facilities).

### Inequity in Health and Housing by Race and Ethnicity

Housing is a social determinant of health and as such, housing instability can exacerbate and/or cause illness. The experience of homelessness is

recognized as both a cause and effect of trauma and its impact on mental and physical health cannot be ignored. Racial and ethnic minority groups in Montana are at greater risk of experiencing homelessness, experience higher rates of unsheltered homelessness across the state [Table 4], and experience worse health outcomes than their white counterparts. According to the US Census Bureau 2017 estimates, Montana residents are 89.1 percent white, 6.7 percent American Indian, .6 percent African American alone, .8 percent Asian alone and 2.8 percent two or more races.<sup>16</sup> Though American Indians in Montana make up just 6.7 percent of the total population in the State, American Indians in Montana are overrepresented among people experiencing homelessness. Among individuals experiencing homelessness in Montana, more than a quarter (28.1%) are American Indian.<sup>17</sup>

When these figures from the U.S. Census Bureau and the U.S. Department of Housing and Urban Development are used to calculate risk it is revealed that American Indians in Montana are nearly five times more likely to experience homelessness when compared to Montana’s white residents. Less than one percent of Montana’s residents are African American, and yet African Americans are five times more likely to experience homelessness when compared to their white counterparts.<sup>18</sup> Disparities in the percent of individuals experiencing homelessness is depicted in Table 5. In following the three data points in the chart below [Table 5], equity in representation would be observed in a straight line—meaning that the percent of white residents in the general population would be mirrored in the percent



<sup>16</sup> United States Census Bureau, Quick Facts Montana, Population Estimates July 1, 2017 by Race and Hispanic Origin. Retrieved from: <https://www.census.gov/quickfacts/mt>

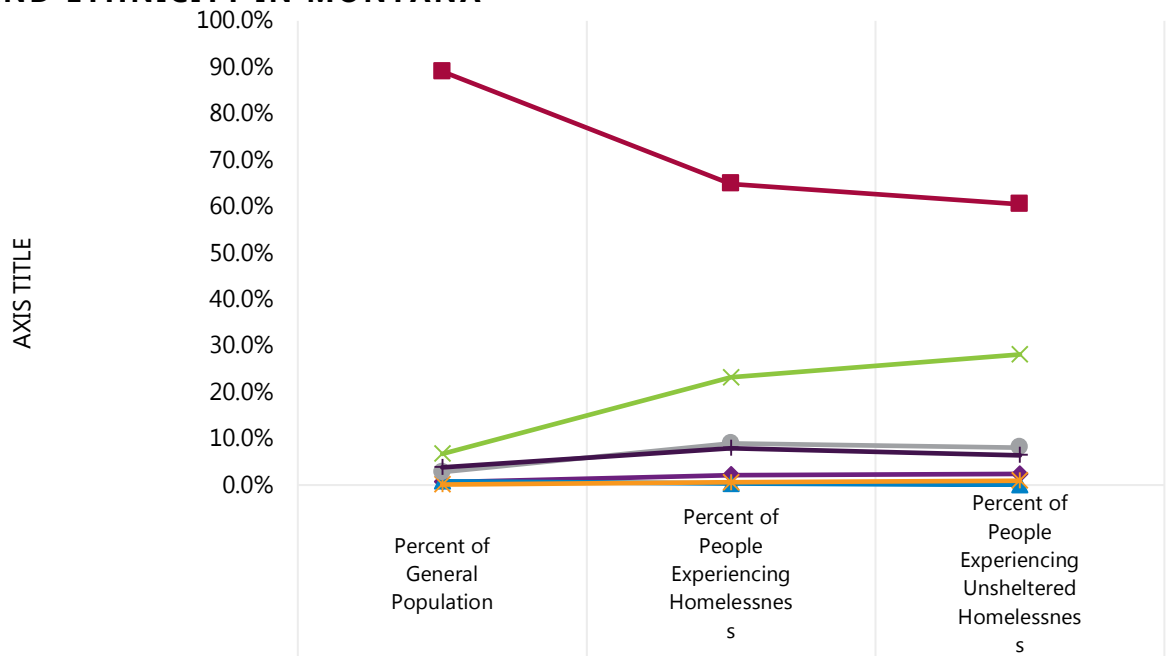
<sup>17</sup> Demographic Summary by Race. HUD 2017 Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations. Retrieved from: [https://www.hudexchange.info/resource/reportmanagement/published/CoC\\_PopSub\\_State\\_MT\\_2017.pdf](https://www.hudexchange.info/resource/reportmanagement/published/CoC_PopSub_State_MT_2017.pdf)

<sup>18</sup> Demographic Summary by Race. HUD 2017 Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations. Retrieved from: [https://www.hudexchange.info/resource/reportmanagement/published/CoC\\_PopSub\\_State\\_MT\\_2017.pdf](https://www.hudexchange.info/resource/reportmanagement/published/CoC_PopSub_State_MT_2017.pdf)

of people experiencing homelessness and unsheltered homelessness. Instead, in this graph American Indian, African American and Native Hawaiian or Other Pacific Islanders experience disparate rates of homelessness, with even greater increases in their representation among people experiencing unsheltered homelessness.

American Indians in Montana also experience poorer health, shorter life expectancies, and higher risk of becoming homeless when compared to Montana’s white population. American Indians in Montana experience higher rates of death due to heart disease, cancer, diabetes, accidents, and other leading causes of death.<sup>19</sup> White women in Montana have a life expectancy of 20 years more than American Indian women and white men in Montana have a life expectancy of 19 years longer than American Indian men.<sup>20</sup> Supportive housing provides the platform for communities to experience safety and stability, better access to healthcare, and ultimately live fuller, healthier lives.

**TABLE 5: EXPERIENCE OF HOMELESSNESS BY RACE AND ETHNICITY IN MONTANA <sup>13</sup>**



Black or African-American	0.6%	2.2%	2.4%
White (including hispanic)	89.1%	64.9%	60.5%
Asian	0.8%	0.3%	0.0%
American Indian or Alaska Native	6.7%	23.2%	28.1%
Native Hawaiian or Other Pacific Islander	0.1%	0.6%	0.9%
Multiple Races	2.8%	9.0%	8.1%
Hispanic or Latino	3.8%	7.9%	6.4%

<sup>19</sup> "Hidden Health Inequalities that American Indian and Alaskan Natives face", The Conversation, 2018.

<sup>20</sup> "The State of the State’s Health", Montana Department of Public Health and Human Services, 2013.

## PART II: KEY ASPECTS OF MONTANA'S STATE MEDICAID PLAN

Montana began its Medicaid expansion in January 2016 after the Medicaid expansion waiver was approved by CMS on November 2, 2015. Enrollment in Montana's expanded Medicaid exceeded expectations with 91,563 Montanans enrolled as of January 2018. As a result of Montana's Medicaid expansion, all Montanans with an income up to 138% of federal poverty level now qualify for Medicaid health insurance which covers the standard health benefits required by the federal government. Prior to the Affordable Care Act (ACA) the average monthly enrollment for Medicaid and the Children's Health Insurance Program (CHIP) was 148,974 Montanans. As of May 2018, the monthly enrollment had increased 87% from pre-ACA numbers and had stabilized at 278,778 Montanans enrolled.<sup>21</sup>

### A. Montana's Medicaid HCBS Waiver Authorities Examined for the Crosswalk

There are four Medicaid HCBS Waivers in Montana that most directly serve people who need supportive housing. Three of these waivers are HCBS waivers<sup>22</sup> that allow individuals to remain in their community and avoid unnecessary institutionalization in long-term care facilities. In addition, the Tribal Health Improvement Program (T-HIP) is a part of the larger Passport Waiver program that includes primary care case management. T-HIP provides additional funding for Federally Recognized Tribes to address health disparities through innovative programs for American Indian populations who reside on Indian reservations.

**1. The Big Sky Waiver** gives the state the authority to offer additional home and community based services to Medicaid members who are over age 65 or living with a disability, who meet the functional criteria of nursing home care but are choosing to live independently in the community, outside of institutional care.

**2. The 0208 Comprehensive Waiver** authorizes home and community based services for Medicaid beneficiaries of all ages with developmental disabilities who meet the criteria for ICF/IID level of care. This waiver provides supportive services to help these individuals increase and maintain independence, with the goal of helping them to achieve and maintain a good quality of life.

**3. The SDMI Waiver** authorizes long term care services in a community setting for individuals with SDMI that meet a nursing home level of care. The SDMI Waiver gives the state the authority to offer additional home and community based services to these Medicaid members so that they can live independently, outside of institutional care.

**4. The Passport Waiver** details the Primary Care Case Management (PCCM) program for Medicaid in Montana. Primary care providers deliver the program, agreeing to serve as the member's health home, provide primary care, and make medically necessary referrals for specialist services, **The T-HIP** was

<sup>21</sup> <https://www.kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

<sup>22</sup> Explanation of Medicaid 1915 Home and Community Based Waivers - <https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS-Roadmap/Resources/State-Federal-Relationships/State-Medicaid-Policies.html>

launched in April 2017 and is available to American Indian Medicaid members living within the exterior boundaries of an Indian reservation who are also enrolled in the Passport Waiver.

### Indian Health Service in Montana

The federal government provides 100 percent payment for services provided to American Indian Medicaid beneficiaries through an Indian Health Service facility, whether operated by an IHS or tribal 638 facility. These facilities are outlined in the section below. If an American Indian Medicaid member does not receive health services through an IHS or tribal 638 facility, the federal government will match the state's payment at the regular Federal Medical Assistance Percentage (FMAP) rate, which is 65.54 percent for Montana for FY2019.

#### 1. Delivery System

A key aspect of the health service delivery system for American Indians is the federal requirement to allow local tribal control of federally funded health services. To that end, the IHS has worked to compact or contract with tribal health organizations to provide the healthcare services to American Indians living on tribal lands. IHS also provides limited grant funding to Urban Indian Health Centers to provide services to American Indians who reside in these specific communities. Although Medicaid offers members choice of providers, American Indians access healthcare in Montana primarily through four mechanisms:

- a. IHS-operated service units** are administered through the Billings Area IHS regional office. IHS service units bill and receive third party revenue from private insurance, Medicare and Medicaid. Each of the IHS service units below provide differing health services, however all seven tribal health departments have FQHC status. Services provided by these service units include, for example, primary care, mental health, dental services, or specialty clinics and referrals.
  - i. Blackfeet Service Unit
  - ii. Crow Service Unit
  - iii. Fort Belknap Service Unit
  - iv. Fort Peck Service Unit
  - v. Northern Cheyenne Service Unit
  
- b. Compact: Tribally operated health departments** that have compacted to provide health services to their Tribe per the Indian Self-Determination and Education Assistance Act. According to IHS, "the Compact sets forth the general terms of the nation-to-nation relationship between the Tribe or Tribal Organization and the Secretary of the US Department of Health and Human Services (HHS)."<sup>23</sup> In addition to providing compacted health services through IHS, providers may also bill Medicaid. There are two tribally operated health departments in Montana that are fully compacted:
  - i. Confederated Salish and Kootenai Tribal Health Department
  - ii. Chippewa Cree Tribe's Rocky Boy Health Center

<sup>23</sup> Frequently Asked Questions, IHS Office of Tribal Self-Governance. Retrieved from: <https://www.ihs.gov/selfgovernance/faq/#5>

- c. *Contract:*** Each Tribe in Montana has contracts with IHS to plan, conduct and administer one or more programs, functions or services that IHS is charged with providing. These contracts occur under the Indian Health Self Determination and Education Act (public law 93-638), and are often referred to as “638 contracts.” The specific 638-contracted programs and services the tribes administer vary greatly but often include substance use disorder treatment, sanitation, public health functions, prevention programs, and less commonly, certain clinical services.
  
- d. *Urban Indian Health Centers*** are nonprofit health organizations that receive grants and contracts from IHS under the Indian Healthcare Improvement Act. There are five Urban Indian Health Centers in Montana, four of which are FQHCs. Each can enroll and receive reimbursement from Medicaid for allowable services.

  - e.** Indian Family Health Clinic, Great Falls (FQHC)
  - f.** North American Indian Alliance, Butte (FQHC)
  - g.** Missoula Urban Indian Health Center, Missoula (FQHC)
  - h.** Helena Indian Alliance, Helena (FQHC)
  - i.** Billings Urban Indian Health and Wellness Center



## PART III: SUPPORTIVE HOUSING SERVICES CROSSWALK FINDINGS

Following is an overview of key aspects of the Montana Medicaid State Plan and Medicaid HCBS Waivers that most relate to supportive housing services.

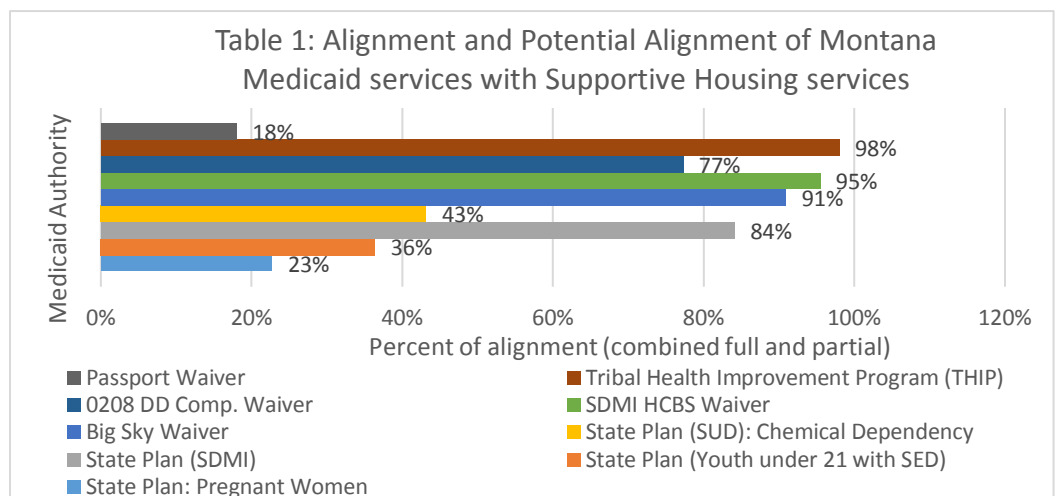
### A. Supportive Housing Services Crosswalk Methodology

To determine the degree to which Medicaid currently pays for supportive housing services, CSH “cross walked” 44 core services provided in supportive housing with key provisions of the Montana State Plan and relevant Montana Medicaid HCBS Waivers that are available to aging adults and individuals living with disabilities including intellectual and developmental disabilities (IDD), SDMI, SUD, high utilizers of crisis healthcare services, youth with emotional disturbances, and pregnant women. CSH then reviewed the initial crosswalk findings with staff from DPHHS to confirm and clarify alignment with specific behavioral health and home and community-based services. Assistance was provided through phone consultation and written correspondence.

CSH also conducted provider interviews with supportive housing providers across the State. These interviews were conducted at the same time as the Medicaid State Plan and HCBS Medicaid Waiver analysis. Sections B, C, and D of the Crosswalk details CSH’s analysis of alignment and gaps identified in the Medicaid State Plan and the HCBS Medicaid Waivers when compared to the services in supportive housing. Section D describes the degree to which supportive housing services are being covered in practice.

### Medicaid State Plan and HCBS Medicaid Waiver Alignment: Supportive housing services clearly covered by the Montana Medicaid program

The Montana Medicaid program covers many of the services necessary for individuals who benefit most from supportive housing. Here is a summary of each of the Medicaid Authorities and the percent of services that align or have potential to align with supportive housing services for specific target populations.



#### 1. Supportive Housing Service Alignment for Individuals Enrolled in T-HIP

The services available for Medicaid members eligible for T-HIP offer significant alignment with supportive housing services, largely in part due to the flexibility granted to the program in addressing social determinants of health, and the program specifically naming housing and housing need as an important factor to be addressed in case management services, if identified as a need during the needs

assessment. The T-HIP services also align well with supportive housing services in that the case management service provider meets the member where they are at in the community and provides a per member per month (PMPM) payment that accommodates the diverse needs of participants and the implementation challenges of serving this population. There are three tiers in the T-HIP. Tier 1 services align with supportive housing as services that address care coordination, outreach and in reach, assisting with accessing resources related to housing need, and basic health education. Tiers 2 and 3 have potential for alignment as they grant the provider flexibility to select a range of services that address population health and the social determinants of health. Nearly every supportive housing service could fall under this category were a provider to choose supportive housing services as one of the interventions covered for Tier 2 or 3. Appendix B includes the full table of services that were “crosswalked” with T-HIP services and the alignment (noted as Y), potential for alignment (P), or lack of alignment (N).

## **2. Supportive Housing Service Alignment for Individuals with SDMI**

More than three quarters (84 percent) of the core supportive housing services examined align with or have potential to align with Montana Medicaid services for individuals with SDMI. The majority of these services fall under services included in the PACT services and Targeted Case Management authorized in the Medicaid State Plan. Waiver services available through the SDMI Waiver, including Peer Support Services, align significantly with supportive housing services, with the majority (96%) of supportive housing services either aligning or having potential to align. Services that have potential to align are housing-related services that are not spelled out explicitly in the Medicaid State Plan or the SDMI Waiver but could be provided if housing needs are assessed, included in the individualized service plan, and medically necessary for skill development and recovery. While the potential exists, state leaders and providers will need to work together to ensure the implementation leads to quality supportive housing services. Issues regarding rates, caseload size, revenue generation for direct service staff and staff expertise will all need to be addressed for this potential to develop into quality supportive housing services. These issues are the case in whatever Medicaid service has potential for alignment, not solely with the services for individuals with SDMI.

## **3. Supportive Housing Service Alignment for Individuals with Intellectual and Developmental Disabilities**

Nearly one third of core supportive housing services align with what is covered by the 0208 Waiver for individuals living with IDD. Additional services have potential for alignment, with a total of 77 percent of supportive housing services aligning or having potential for alignment.

The covered 0208 Waiver services that best align with supportive housing include: Behavioral Support Services, Personal Support, Community Transition, Residential Habilitation, and Day Supports. Additionally, while many waivers have waitlists that are chronological “first come first served,” the 0208 Waiver has made exemptions for individuals experiencing a loss of housing, inappropriate hospitalization, or imminent discharge from a temporary placement.

## **4. Supportive Housing Service Alignment with the Big Sky Waiver**

The Big Sky Waiver provides services for seniors over the age of 65 and individuals living with disabilities and meet the functional criteria for institutional care to remain living in the community with

home based care services. The Big Sky Waiver services that best align with or have potential to align with supportive housing services include Community Transition Services, Specially Trained Attendants under Personal Assistance Services, and Supported Living Services. Community Transition Services, while robust in the array of housing transition services covered, are only available to individuals exiting private pay institutions or residential services and therefore would not be available to individuals experiencing homelessness. Additionally, Supported Living Services are long-term services reserved for individuals requiring the highest level of care and are not available to everyone eligible for the Big Sky Waiver.

Finally, it should be noted that many of the covered services mentioned in this report require that the member have a diagnosis of a SDMI or qualify for one of the waiver programs. Qualifying for a Waiver program does not guarantee that an individual will receive services under the Waiver, as Waiver programs are not entitlement programs and often have waitlists. Waitlists for Waiver programs can be a significant barrier to receiving the right care at the right time in the community.

### **5. Service Alignment for Individuals with SUD**

Fewer supportive housing services aligned (11%) or had potential to align (32%) with the covered services available to Montana residents with diagnosed SUD. Many individuals experiencing homelessness in need of SUD services have co-occurring substance use disorders and mental illness diagnoses, but not all. For individuals who only have a diagnosed SUD the majority of the services identified with potential included Targeted Case Management (TCM) and peer support services. As part of the Medicaid State Plan, there is no waitlist for TCM services for individuals with SUD who meet the eligibility requirements. Peer Support Services for SUD are not currently funded through Montana Medicaid, they are funded through Federal Block Grants. In 2017, the Montana Legislature passed a bill to give the Board of Behavioral Health the authority to certify Peer Support Specialists. This is relevant to the future alignment of SUD services with supportive housing services. The complete list of supportive housing services and how they do or do not align with Montana Medicaid can be found in Appendix B.

#### **Supportive housing services with potential for alignment**

CSH has identified multiple supportive housing services that have the potential for coverage under the current Montana State Plan, yet the certainty of this coverage remains vague due to state plan language and program standards that were not originally written to explicitly cover supportive housing services. In June 2015, CMS issued a bulletin on supportive housing pre-tenancy and tenancy support services that federal Medicaid now considers reimbursable.<sup>24</sup> The informational bulletin outlines how states can go about making changes to their current Medicaid State Plan and Waivers to include these newly recognized supportive housing services. The clear language outlining supportive housing pre-tenancy and tenancy support services within the CMS bulletin offers a guide for states looking to promote best practices by clarifying which supportive housing services are covered in their state plans and waivers.

<sup>24</sup> CMCS Informational Bulletin, "Coverage of Housing-Related Activities and Services for Individuals with Disabilities," June 26, 2015. <https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-06-26-2015.pdf>

While the informational bulletin was published in 2015 under the Obama administration, the Trump administration has approved state plan amendments and waivers that include tenancy support services in 2017 and 2018.<sup>25</sup> CSH regularly tracks state actions related to Medicaid and tenancy support services. A summary of the most recent activity in state plan amendments and waivers to cover supportive housing services through Medicaid can be found [here](#).

In Montana, many of these CMS defined pre-tenancy and tenancy support services have the potential for alignment. Table 2 below outlines the supportive housing service and the corresponding Medicaid service that could potentially support Medicaid reimbursement.

<b>Table 2: Supportive Housing Services with Potential for Medicaid Coverage</b>	
<b>Supportive Housing Service</b>	<b>Comparable Medicaid Benefit with Potential for Alignment (if service provider and client know to ask about and recognize housing need as impacting health and include in assessment and service plan)</b>
Assessment of housing preferences and barriers related to tenancy	Assessment with a comprehensive history
Housing Service Plan	Individualized service plan development
Identification of resources to cover moving and start-up expenses	Community Transition Services for people exiting institutions, and referrals to social services and housing under the Passport Waiver
Assistance with move-in arrangements	Community Transition Services for people exiting institutions, PACT services, if medically necessary
Assistance with collecting required documentation (i.e. birth certificate, IDs, credit history)	Community Transition Services for people exiting institutions, PACT services, if medically necessary
Assistance with housing search and housing applications	Community Transition Services for people exiting institutions, PACT services, if medically necessary
Early identification/intervention for behaviors that could jeopardize successful tenancy/housing retention	Psychosocial Assessment with a comprehensive service plan development, PACT, Life Coach services, Residential Habilitation Services, and Peer Support Services
Ensuring housing unit is safe and ready for move-in	PACT, Peer Support Services, Community Transition services, Specially Trained Attendant (STA for Big Sky Waiver)
Assistance resolving disputes with landlords, property management, and neighbors	PACT, Peer Support Services, Behavioral Support Services (DD Waiver), Life Coach (SDMI Waiver), STA (Big Sky Waiver)
Linkage with community resources to prevent eviction/ sustain tenancy	PACT, Peer Support Services, Personal Supports (DD Waiver), Life Coach (SDMI Waiver), STA (Big Sky Waiver), Referrals (Passport), Targeted Case Management
Ongoing training and support with activities related to household management and tenant habits	PACT, Peer Support Services, Personal Supports (DD Waiver), Life Coach (SDMI Waiver), STA (Big Sky Waiver),
Development of housing support crisis plan	Service plan development and crisis Plan development

<sup>25</sup> Summary of State Actions, Medicaid & Housing Services, Updated November, 2018. CSH. <https://d155kunxf1aozz.cloudfront.net/wp-content/uploads/2018/11/Summary-of-State-Action-Medicaid-and-Supportive-Housing-Services-2018-11.pdf>

## **1. Service Plan Development: An example of potential alignment and what it means**

Part of the Crosswalk analysis included examining services provided under PACT for individuals with SDMI. One example of a potentially aligned service includes the housing support service plan. While the Medicaid State Plan does not overtly mention housing service plans as covered, it does cover individualized treatment plans under PACT. The Montana State Medicaid Plan does not exclude housing goals from being included in an individual's self-identified goal within their treatment plan, yet it does not specify inclusion of housing goals either. Therefore, if a member with a mental health diagnosis of schizophrenia identifies remaining in her apartment as one of her recovery goals for her treatment plan, this member could work with her case manager to develop a housing supports service plan as a component of her case management treatment plan. The time then spent developing the housing supports service plan may be covered by Medicaid. This is because the service plan is a Medicaid covered service and the member identified housing stability as one of her recovery goals that supports her mental health and wellness. It is important to also note that PACT is reimbursed through a daily rate per person per day in Montana.

The housing service plan is an example of "potential alignment" with the Medicaid State Medicaid Plan, because had this member not specified housing as a personal goal for her treatment plan, the development of a housing service plan would not be covered by Medicaid. Greater clarity is needed in the Medicaid State Plan and relevant waivers to ensure that tenancy support services related to a member's health and recovery goals are covered.

Currently, if an auditor determines during a quality review that they do not believe housing to be a medically necessary goal the claim could also be denied. Without written clarification from the State regarding details of covered supportive housing services the coverage of most of CMS' defined "pre-tenancy and tenancy sustaining supports" remain ambiguous at best.

## **2. Potential Alignment in Supportive Housing for Other Target Populations**

In addition to the target populations mentioned above, CSH examined services provided under the Montana Medicaid State Plan for youth and pregnant women as well as the HIP case management services for individuals with chronic illnesses or risks of developing serious health conditions. While there was little in these covered services that clearly aligned with supportive housing services, there was potential for alignment in several service categories, including targeted case management, assessments that include comprehensive client histories, service planning, and referrals to other social service and housing providers.

### **State Plan Gaps**

Some supportive housing services do not align with the current Montana State Medicaid Plan. Some individuals in need of supportive housing do not align with the functional criteria required by HCBS Waiver yet would benefit greatly from supportive housing services. Others may have a SUD but do not have a primary diagnosis that makes them eligible for the robust range of services that align with supportive housing (like those for people with diagnosed SDMI). These *gaps* in service are highlighted below and are also addressed in the Recommendations section [Part IV] at the end of this report. The following key gaps exist in the provision of the following supportive housing services:

## 1. Gaps in Populations Served<sup>26</sup>

Currently, individuals who have a primary diagnosis of SUD are not covered for the majority of core supportive housing services under the Medicaid State Plan. TCM services appear to align best with supportive housing services, however limitations on who can provide the case management services and the lack of clarity on including housing needs in assessments and service planning leaves room for individual provider interpretation for services that can be provided under TCM. The gap in Medicaid coverage and need for supportive housing services for homeless individuals with SUD is a serious concern among providers and advocates as these individuals made up 17.7 percent of individuals experiencing homelessness in the State's most recently published Point in Time Count<sup>27</sup>.

Additionally, it is important to note that the experience of homelessness is in and of itself a traumatic event. Many individuals experiencing homelessness have symptoms of Post-Traumatic Stress Disorder (PTSD). Supportive housing provides the stability that individuals need to address trauma and illness and move toward recovery, meaning oftentimes diagnoses are not made until an individual is stabilized in housing and has periods of sobriety that allow a medical practitioner to assess symptoms without the interference or influence of substances.

## 2. Gaps in Supportive Housing Services

The gaps identified below are services that are a part of the package of evidence-based practices for supporting individuals to live successfully in supportive housing yet are not explicitly included as covered services in the Medicaid State Plan for individuals experiencing homelessness<sup>28</sup>.

- Outreach and In-reach (Available in T-HIP but few others)
- Assistance with collecting required documentation (many cover referrals but not direct assistance with collecting required documentation)
- Assessment of housing preferences and barriers related to tenancy
- Assistance with housing search and housing applications
- Identification of resources to cover moving and start-up expenses
- Ensuring housing unit is safe and ready for move-in
- Assistance with move-in arrangements
- New tenant orientation/move-in assistance
- Tenant's rights education/introduction to tenant's council
- Education/training on tenant and landlord rights/responsibilities
- Ongoing training and support with activities related to household management and healthy tenant habits

<sup>26</sup> This Crosswalk examined target populations that are highlighted in the State Medicaid Plan and interact with the healthcare system. It is important to note that some individuals experiencing homelessness also have experiences with the justice system. Housing and service providers interviewed confirmed the challenges experienced in housing individuals with certain criminal backgrounds. Landlord engagement efforts and project based supportive housing developments will be critical to address these challenges.

<sup>27</sup> Montana HUD Point in Time Count 2018, <http://mthomelessdata.com/2018/>

<sup>28</sup> The exception to this is for individuals with ID/DD who apply for the 0208 Waiver, are exempted from the waitlist for loss of housing, but also meet the Community Transition criteria.

- Coaching on developing and maintaining relationships with landlord/property manager/neighbors
- Assistance resolving disputes with landlords, property management, and neighbors
- Assistance with housing recertification
- Assistance with acquiring furnishings
- Transportation to social service appointments and non-medical services

### **Interviews with Supportive Housing Service Providers**

The following section builds upon the analysis of covered supportive housing services and gaps in coverage in Montana’s Medicaid State Plan and Waivers and presents identified gaps in practice. CSH conducted interviews with six supportive housing providers across Montana to understand the array of services that supportive housing providers are currently offering to tenants, regardless of the funding source. CSH also surveyed these same providers about their understanding of Medicaid reimbursement of supportive housing services. The information gained during the provider interviews is useful because it highlights the valuable services supportive housing providers are currently offering tenants without Medicaid reimbursement, either because those services are not currently covered in the Medicaid State Plan or HCBS Waivers, or because providers do not perceive them as Medicaid reimbursable services. This provider interview section included in the Crosswalk Report can be helpful for advocates and community leaders in support of the CMS recommended covered services for pre-tenancy and tenancy support services as well as those looking to expand provider education of the Medicaid State Plan and HCBS Waives.

The supportive housing providers interviewed for Crosswalk represented a range of provider types, including three social services agencies, a health department, and two housing authorities. For the purposes of discussion, the term provider is extended to all agencies who were interviewed including the Health Department and housing authorities. Provider interviews included a series of questions around provider perceptions of Medicaid Assistance coverage for over 80 services within 17 service categories. Providers were interviewed from Helena, Missoula, and parts of Northwest Montana. Not all providers interviewed had experience with billing Medicaid, and only one provider is currently in the process of starting to bill Medicaid for services provided to supportive housing tenants. All providers understood Medicaid services and have knowledge either through experience billing for Medicaid or working with partners who are currently or were billing for Medicaid.

### **1. Perceptions of Medicaid by Providers and Provider Recommendations**

During provider interviews two key themes emerged on provider perceptions of Medicaid: the critical importance of Medicaid expansion in Montana and challenges with recent budget cuts.

Providers described the impact of Medicaid expansion in Montana as “changing the world” (of health services) detailing how providers were able to expand services and hire additional staff as a result of new enrollees. One provider shared that Medicaid expansion resulted in growing from one Licensed Addictions Counselor (LAC) to five LACs on staff. Providers also praised Medicaid enrollment efforts and discussed the impact of having a dedicated person as a certified applications counselor. The Helena Indian Alliance shared that having a dedicated certified applications counselor significantly increased the number of insured individuals receiving services at the Urban Indian clinic.

Providers discussed the challenges with the cuts and the lack of tenancy support services and gaps as a result. Medicaid budget cuts are rare in Montana and it is important to note that cuts occurred just prior to the interviews. During the writing of this report some cuts were reversed.

Providers communicated a desire to provide higher quality and more comprehensive services. Services funding remains a concern for providers, who noted challenges around capacity building, sustainable and comprehensive services, and their relationship to services funding. Some providers shared the relationship between adequate cash flow, financial reserves, and serving the most vulnerable clients.

All providers interviewed recognized the role that stable housing plays in individuals' health outcomes and the roles that access to services can play in maintaining stable housing. One provider, Rimrock, shared results from a recent client survey which highlighted that 45.9% of clients served in 2017 had experienced homelessness at some point in their lives. The same study revealed that while nearly 14% of clients were experiencing homelessness at entry (inpatient, intensive outpatient combined), fewer than 3% were experiencing homelessness after 12 months. Rimrock shared in this report that the number of clients experiencing homelessness seems to grow each year.<sup>29</sup>

## **2. Supportive Housing in Tribal Communities**

Supportive housing providers operating in tribal communities were contacted for interviews, however the degree to which all tribal communities are engaged in supportive housing remains unclear at the time of this report. Through one provider interview, an example of involvement in supportive housing was identified. A tribal health organization currently partners with their local Public Housing Authority to provide supportive services in the Housing Authority's HUD funded Permanent Supportive Housing program. The health organization also serves as a "warm handoff" agency, supporting individuals in accessing the Housing Authority for evaluation and prioritization using the VI-SPDAT tool. This warm handoff often includes providing transportation to assessment and evaluation sites and helping individuals navigate through the process of getting a mental health evaluation and completing a VI-SPDAT assessment. This partnership is unique to the tribal health organization. The organization has funded a case manager through its FQHC Prospective Payment System (PPS) rate. The case manager works with 10 tenants, who have received vouchers from the Housing Authority, providing supportive services from the tribal health program. The partnership provides access to supportive housing that was not otherwise available to the organization's patients.

It is likely that more tribal communities are engaged in supportive housing activity, whether it is identified specifically as such. Federal funding for housing assistance in tribal communities is administered through Tribally Designated Entities (THDE's). These organizations receive funding directly from HUD's Office of Native American Programs (ONAP) to operate a variety of programs to address housing needs, including home loan guarantee programs, low income rental programs, and home repair. It is important to note that a primary funding source for Supportive Housing, HUD's Continuum of Care program, is not available to tribes and tribal organizations. However, formula funding through

<sup>29</sup> Rimrock. 2017 Adult Patient Census and Survey Results. July 2017.



the Indian Housing Block Grant (IHBG) and the Indian Community Development Block Grant (ICDBG) allows THDE's flexibility in designing programs that meet the housing needs of tribal communities and could be a source for the housing assistance necessary for supportive housing. There are seven Tribal Housing Authorities in Montana:

- |  |   |
|--|---|
| 1) Apsaalooke Tribal Housing Authority, Crow Agency    | 5) Fort Peck Housing Authority, Poplar            |
| 2) Blackfeet Housing Authority, Browning               | 6) Northern Cheyenne Housing Authority, Lame Deer |
| 3) Chippewa-Cree Housing Authority, Box Elder          | 7) Salish & Kootenai Housing Authority, Pablo     |
| 4) Fort Belknap Housing Authority, Fort Belknap Agency |   |

Authors of this report requested interviews with tribal housing or tribal health organizations, specifically the Urban Indian Health Centers, and received a limited response during the time allotted for this study. Five organizations were contacted resulting in two organizations reached and interviewed. One interview was conducted with a tribally operated health department that is contracted through IHS and the other interview was with an Urban Indian Health Center. Highlights of the conversations with both organizations:

- Medicaid expansion is critical to the sustainability of the tribally operated health department and it allows the health department to grow and expand programs without seeking additional grant funding.
- One of the Urban Indian Health Centers is not yet able to currently bill for Medicaid because they are still waiting for their FQHC designation, which has been delayed by the CMS regional contractor. According to the Urban Indian Health Center, delays and a lack of understanding of tribal process by CMS is not uncommon.
- One Urban Indian Health Center shared that they do not have capacity to provide tenancy supports. Staff make referrals for tenancy support services but are not able to provide any tenancy support. There is need for additional housing resources and tenancy supports.
- Barriers related to staffing ratios in supportive housing, housing vouchers, and the availability of security deposits for individuals in supportive housing choosing to move to another unit remain challenging for tribal health organizations providing supportive housing services.
- A promising practice in overcoming barriers for American Indians to enroll in Medicaid is for tribal health departments to have designated staff that can determine Medicaid eligibility for tribal residents. The State of Montana has provided funding to tribal health departments to staff these positions. This has helped American Indians overcome challenges related to racial discrimination and lack of cultural competency when seeking assistance through non-tribal entities.

Efforts to identify and engage these organizations into the conversation around leveraging Medicaid should continue to be pursued as these groups have a unique perspective shaped by their jurisdictional sovereignty, housing and health funding mechanisms, and supportive housing needs.

### **3. Supportive Housing Provider Identified Gaps in Covered Services and Reimbursement**

Interview questions examined providers' understanding of the Medicaid State Plan and its coverage of services related to supportive housing. Most of the providers interviewed did not have experience with billing Medicaid for supportive housing. An assessment of supportive housing providers' perceptions of covered supportive housing services helps to inform advocates and community leaders of areas for provider education and training. In the interviews CSH found the supportive housing providers reported that they did not believe *or* were unsure if the following services were covered by the Medicaid State Plan.

- Assessment
- Outreach and In-Reach Services
- Support Groups
- Independent Living Skills

### **4. Array of Services Currently Delivered by Supportive Housing Service Providers**

Most supportive housing providers interviewed provided the full range of pre-tenancy and tenancy supportive services, but there was a sense that there was not enough staff capacity to provide fully comprehensive services with some providers. The baseline of services currently offered by most providers includes the following.

- Assessment
- Pre-Tenancy Supports
- Housing Stabilization Services
- Service Plan Development
- Case Management and Service Coordination

## **PART IV: CSH RECOMMENDATIONS**

The state of Montana is making strides to eliminate health disparities and create a system of care that addresses the social determinants of health, providing the right level of care, to the right people, at the right time. These efforts will help to curb healthcare costs while improving care for Montana's most vulnerable residents. Following the completion of the Crosswalk research, below are CSH recommendations for the State of Montana, its providers and advocates.

### **A. Define and cover supportive housing services using CMS guidelines for a 1915i State Plan Amendment for individuals in priority populations who are experiencing homelessness, exiting institutions, and/or frequent users of crisis systems who need community based supportive housing services to live independently.**

Supportive Housing Services should be explicitly included in the Montana State Plan to align with CMS guidelines of pre-tenancy and tenancy-sustaining services included in its Informational Bulletin released on June 26, 2015. CMS is currently supporting states to develop and request 1915i State Plan Amendments or SPAs to include tenancy support services as part of their Home and Community Based services package. The 1915i SPA requires the state to develop needs-based criteria and allows the state to cover individuals who do not yet meet institutional levels of care. CSH recommends that DPHHS connect with their CMS representative to raise questions about 1915i SPA implementation in frontier states, like Montana, given challenges that may arise with conflict-free case management requirements that accompany 1915i SPAs.

Given the variety in service packages and service funding sources for different priority populations, CSH is recommending a 1915i SPA that would cover all priority populations with explicit language around housing support services. Currently in Montana some Medicaid-funded services (ex. comprehensive assessments and service planning for the T-HIP and Community Transition services) include specific language guiding providers to assess for housing need and to assist with housing resources, this clear guidance around housing support services is limited and does not extend to all subpopulations of Montanans who would benefit from supportive housing services. Other services like peer supports are currently funded by block grants rather than Medicaid reimbursement and are not accessible to all priority populations identified as needing supportive housing. Mental health and substance use providers that currently provide case management and/or PACT services should be consulted by the State as proposed changes to supportive housing are planned and implemented to ensure the continuum of services and supports are strengthened and not diminished.

To begin this process of including supportive housing services CSH recommends that DPHHS examine supportive housing need data and run data on priority populations to better understand and define who might qualify for the benefit and the number of eligible individuals residing in the Montana that meet the qualification criteria. CSH also recommends that DPHHS continue to consult with CMS and track the movement and progress of other states who have recently submitted 1915i State Plan Amendments for supportive housing. For example, Minnesota recently submitted a 1915i SPA that includes persons who are experiencing chronic homelessness and Montana should carefully track CMS' response to Minnesota's request and consider how their experience can inform any upcoming requests made of CMS.

Finally, the state should consider a per diem or Per Member Per Month (PMPM) financing system for case management and tenancy support services, to ensure maximum flexibility for the provider network. CSH is available for consultation to further explore these options with the state. CSH recommends that DPHHS consider PMPM reimbursement for behavioral health services like case management, in addition to tenancy supports, to ensure consistency in roll out.

**B. Examine state program standards that could be more comprehensive in addressing social determinants of health (SDOH) needs of program participants, specifically housing.**

Program standards that include housing stability would allow the state to signal their priorities around SDOH and specifically housing to the broader community. The state could include creating behavioral health program standards to require the inclusion of housing stability and housing needs in assessment and treatment planning for individuals with SDMI, SUD, frequent users of crisis systems, and individuals exiting institutions (similar to how housing assessment is required in the PACT program). Another example would include covering and expanding community transition services for individuals experiencing unsheltered homelessness, individuals exiting shelters and transitional housing. Many waivers have waitlists that are chronological “first come first served,” however, the 0208 Waiver has made exemptions for individuals experiencing a loss of housing, inappropriate hospitalization, or imminent discharge from a temporary placement. CSH recommends that other HCBS services make this same exemption to their waitlists for individuals experiencing a loss of housing or homelessness and that the term “imminent discharge from a temporary placement” apply to exiting shelters.

**C. Identify flexible resources that are needed for outreach and engagement for individuals in need of supportive housing to ensure that they are assessed and supported in gathering of documents, choice regarding housing options and engagement in services.**

Agencies will need non-Medicaid funded support to engage persons who are unsheltered and can be difficult to locate consistently. Flexible, non-Medicaid funded resources will continue to be needed to cover staff travel and transportation time and outreach efforts that do not result in finding the individual, as serving individuals experiencing unsheltered homelessness often requires multiple outreach attempts for each successful encounter.

**D. Continue efforts to ensure Tribal communities receive education and support to assist individuals in enrolling in and utilizing Medicaid benefits, particularly the opportunity to use T-HIP to advance supportive housing services through Tier 2 and 3 programming.**

The T-HIP program offers a unique opportunity for providers to create programming that addresses the social determinants of health, including housing. Supportive housing programs can target different subpopulations like transition-aged youth, seniors, families involved in the child welfare system, individuals exiting the criminal justice system or other institutional care, or people experiencing homelessness. The Per Member Per Month (PMPM) reimbursement rates available through Tier 1, 2, and 3 offer a unique opportunity to supportive housing providers to expand services to individuals and families experiencing housing instability or at risk of homelessness, as well as to those already experiencing homelessness. Using the T-HIP program funding for supportive housing services could free up other federal supportive housing funding to be used for additional supportive housing resources. CSH recommends that the State continue to work with Tribal Nations to more fully

understand how Tribal Nations are funding and operating supportive housing and to work together to explore opportunities for T-HIP Tiers 2 and 3 to include supportive housing services.

**E. Build capacity for behavioral health and housing service provider networks by promoting training and technical assistance for 1) supportive housing providers to become Medicaid providers and bill Medicaid and 2) behavioral health and waiver providers to understand the quality standards in supportive housing and service partnerships unique to supportive housing in rural areas.**

Current supportive housing and housing service providers are in need of additional service funding yet remain skeptical about reimbursement from Medicaid. Should Montana pursue the inclusion of supportive housing services into its Medicaid State Plan through a 1915i State Plan Amendment, provider education and technical assistance will be critical for engaging and supporting housing service providers through the Medicaid provider enrollment process and through submitting claims for supportive housing services. Start-up costs for new Medicaid providers should also be examined with technical assistance offered to those pursuing incorporating new Medicaid services into their service funding model. Providers interviewed (both healthcare and housing authority staff) expressed interest in training around quality supportive housing best practices and building strategic partnerships to provide quality supportive services. Additionally, mental health and substance use providers that currently engage in supportive housing activities and services should be consulted to ensure that the services and partnerships are strengthened and not diminished by any State Plan Amendment for supportive housing.

Community Mental Health Centers currently offer the full spectrum of care and can scale services up and down based on client need. Many of CMHC services align with or have potential to align with supportive housing services. CMHCs can make excellent service provider partners for existing supportive housing programs and should be included in conversations as many supportive housing providers described serving large geographic areas that create the need to partner to reach all supportive housing tenants. While the potential for alignment and partnerships exists, state leaders and providers will need to work together to ensure the implementation leads to quality supportive housing services. Issues regarding rates, caseload size, revenue generation for direct service staff and staff expertise will all need to be addressed for this potential to develop into quality supportive housing services. These issues are the case in whatever Medicaid service has potential for alignment, not solely with the services for individuals with SDMI.

## Appendix A: Core Services in Quality Supportive Housing

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# Core Supportive Housing Services

### Pre-Tenancy

- Outreach and in-reach services
- Assessment of housing preferences/ barriers related to tenancy
- Development of individualized housing support plan
- Identification of resources to cover moving and start-up expenses
- Ensuring housing unit is safe and ready for move in
- Assistance with move-in arrangements
- Assist in collecting required documentation
- Assist with housing search and completing housing applications
- Development of housing support crisis plan
- Development of re-housing plan: ongoing services to re-house

### Housing Stabilization & Tenancy Sustaining

- Early identification and intervention for behaviors that may jeopardize housing
- Education on tenant and landlord rights and responsibilities
- Eviction prevention planning & coordination
- Coaching on developing/maintaining relationships with landlords/property managers
- Assistance resolving disputes with landlords and/or neighbors
- Advocacy/linkage with community resources to prevent eviction
- Assistance with credit repair activities and skill building
- Assistance with housing recertification process
- Review//modify housing support plan and eviction prevention plan with tenant
- Housing stabilization services
- Continued training on tenancy and household management
- Home Visiting

### Service Coordination

- Housing-focused care coordination (hospital/jail discharge planning, housing liason for tenant's care providers)
- Community integration information and referral
- Non-emergency Transportation
- On call crisis support/intervention
- Assistance with accessing community provider services
- Basic Health & Wellness Education
- Peer Support

## Appendix B: Montana Supportive Housing Medicaid Crosswalk Table

Core supportive housing services and how they align (Y), have potential to align (P)<sup>30</sup>, or are not aligned (N) with the services covered by Montana’s Medicaid State Plan and Waivers.

	Supportive Housing Service Category	State Plan: Pregnant Women	State Plan (Youth under 21 with SED)	State Plan (SDMI)	State Plan (SUD): Chemical Dependency	Big Sky Waiver	SDMI HCBS Waiver	0208 DD Comp. Waiver	Tribal Health Improvement Program (T-HIP)	Passport Waiver
<b>Pre-Tenancy Support Services</b>										
1	Outreach and In-reach services	N	N	N	N	N	N	N	Y	P
2	Assessment of housing preferences/ barriers related to tenancy	N	N	P (PACT)	P (TCM)	P	P	N	Y	P
3	Development of individualized housing support plan	N	P	Y (PACT)	N	P	P	N	Y	P
4	Identification of resources to cover moving and start-up expenses	N	N	N	N	P	Y	Y	Y	N
5	Ensuring housing unit is safe and ready for move in	N	N	P (PACT)	N	P	P	P	P	N
6	Assistance with move-in arrangements	N	N	P (PACT)	N	P	P	P	Y	N
7	Assist in collecting required documentation	N	N	P (PACT)	N	P	P	P	Y	N
8	Assist with housing search and completing housing applications	N	N	P (PACT)	N	P	P	P	Y	N
9	Development of housing support crisis plan	N	P	Y (PACT)	P (TCM)	P	P	P	P	N
10	Eviction prevention planning & coordination	N	P	P (PACT)	N	P	P	P	P	N
11	Development of re-housing plan: ongoing services to re-house	N	N	P (PACT)	N	P	P	P	P	N
<b>Tenancy Sustaining Supports</b>										
12	Early identification/intervention for behaviors that may jeopardize housing	N	P	Y (PACT)	N	P	Y	Y	P	N
13	Education/training on tenant and landlord rights and responsibilities	N	N	P (PACT)	N	P	P	P	P	N

<sup>30</sup> While the potential exists, state leaders and providers will need to work together to ensure the implementation leads to quality supportive housing services. Issues regarding rates, caseload size, revenue generation for direct service staff and staff expertise will all need to be addressed for this potential to develop into quality supportive housing services. These issues are the case in whatever Medicaid service has potential for alignment, not solely with the services for individuals with SDMI.

14	Coaching on developing/maintaining relationships with landlords/property managers	N	P	P (PACT)	P	P	P	Y	P	N
	<b>Supportive Housing Service Category</b>	<b>State Plan: Pregnant Women</b>	<b>State Plan (Youth under 21 with SED)</b>	<b>State Plan (SDMI)</b>	<b>State Plan (SUD): Chemical Dependency</b>	<b>Big Sky Waiver</b>	<b>SDMI HCBS Waiver</b>	<b>0208 DD Comp. Waiver</b>	<b>Tribal Health Improvement Program (T-HIP)</b>	<b>Passport Waiver</b>
15	Assistance resolving disputes with landlords and/or neighbors	N	N	P (PACT)	P	P	P	Y	Y	N
16	Advocacy/linkage with community resources to prevent eviction	N	N	N	Y (TCM)	P	Y	Y	Y	N
17	Assistance with credit repair activities and skill building	N	N	Y (PACT)	N	Y (STA)	Y	P	Y	N
18	Assistance with housing recertification process	N	N	P (PACT)	N	P	Y	P	Y	N
19	Coordination with tenant to review/update/modify housing support plan and eviction prevention plan	N	N	P (PACT)	N	p	P	P	P	N
20	Continued training on being a good tenant and on-going support with activities related to household management	P	P	P (PACT)	P (peer coaching)	Y	P	P	P	N

### Housing Stabilization & Service Coordination

21	Housing stabilization services	N	P	P (PACT)	N	P (STA)	P	P	P	N
22	Housing focused care coordination with other community providers (direct communication with other providers regarding client well-being) (hospital/jail discharge planning, housing liaison for tenant's care providers)	N	P	P (PACT)	P (TCM)	Y (SL)	P	N	Y	N
23	Service Coordination (arranging referrals, tracking appointments and follow-up, scheduling of visits, medical transport, repairs, and appointments)	N	P	Y (PACT)	Y (TCM)	P	Y	N	Y	Y
24	Harm-reduction services (housing-retention focused)	N	N	P	N	N	P	N	P	N
25	Non-emergency Transportation	P	N	N	N	P	Y	P	Y	N
26	Supportive Services	N	P	Y (PACT)	Y	P	Y	Y	Y	N
27	Engagement Specialist Services	N	N	Y (PACT)	P	Y (STA)	Y	N	Y	N



28	On call crisis support/intervention	N	P	Y (PACT)	Y	Y (SL)	Y	N	P	N
	<b>Supportive Housing Service Category</b>	<b>State Plan: Pregnant Women</b>	<b>State Plan (Youth under 21 with SED)</b>	<b>State Plan (SDMI)</b>	<b>State Plan (SUD): Chemical Dependency</b>	<b>Big Sky Waiver</b>	<b>SDMI HCBS Waiver</b>	<b>0208 DD Comp. Waiver</b>	<b>Tribal Health Improvement Program (T-HIP)</b>	<b>Passport Waiver</b>
29	Assistance with accessing legal support	N	P	P	P	Y (SL)	Y	P	Y	P
30	Assistance and education with accessing food and nutrition	P	P	P	N	Y (SL)	Y	Y	Y	P
31	Peer support services	N	N	Y (PACT)	Y	N	Y	P	P	N
32	Basic Health & Wellness Education	P	N	Y (PACT)	N	Y	Y	N	Y	Y
<b>Independent Living Skill Building</b>										
33	Interpersonal communication skills	N	P	Y (PACT)	P	Y (STA)	Y	Y	P	N
34	Conflict resolution/mediation training	N	P	P	P	Y (STA)	P	Y	P	N
35	Personal financial management and budgeting	P	N	P	N	Y (STA)	Y	P	P	N
36	Credit counseling	N	N	N	N	Y (STA)	Y	P	P	N
37	Representative payee	N	N	N	N	N	N	N	N	N
38	Entitlement assistance/benefits counseling	N	N	P	P	Y (STA)	Y	P	Y	N
39	Training in cooking/meal preparation	P	N	P	N	Y (STA)	Y	Y	P	N
40	Training in personal hygiene and self-care	P	N	P	P	Y (STA)	Y	Y	P	N
41	Training in housekeeping	P	N	N	N	Y	Y	Y	P	N
42	Training in use of public transportation	P	N	P	P	Y	Y	P	P	N
43	Assistance with activities of daily living	P	P	Y (PACT)	P	Y	Y	Y	P	N
44	Ongoing training and support with activities related to household management and healthy tenant habits	P	N	P	P	P	Y	Y	Y	P
	Total Yes	0%	0%	27%	11%	41%	55%	32%	48%	5%
	Total Partial	23%	36%	57%	32%	50%	41%	45%	50%	14%
	Total No	77%	64%	16%	52%	9%	5%	23%	2%	81%
		100%	100%	100%	95%	100%	100%	100%	100%	100%
	Yes and Partial	23%	36%	84%	43%	91%	95%	77%	98%	19%