State Investments in Supportive Housing: An Inventory of State Efforts

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STATE Health & Value STRATEGIES | *Driving Innovation Across States*

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Overview of Select States Using 1915(c) Waivers to Offer Supportive Housing Benefits

1915(c) HCBS Waivers

State/Program Name	Effective Dates	Target Population	Eligibility Criteria	Supportive Housing Benefits
Louisiana Residential Options Waiver (ROW): 1915(c) HCBS Waiver[1]	July 1, 2018 through June 30, 2023	Individuals with autism and I/DD transitioning from an intermediate care facility to their own home/community	Eligible individuals must meet Louisiana Medicaid eligibility and: › Meet the Louisiana definition for Developmental Disability which manifested prior to age 22 (Revised Statute 25:451.2, Paragraph (11) › Have an Office of Citizens with Developmental Disabilities Statement of approval › Meet Intermediate Care Facility-Intellectual Disability (ICF-ID) Level of Care Criteria › Meet financial and non-financial Medicaid eligibility criteria for home and community-based waiver services: income equals 300 percent of the Supplemental Security Income (SSI) Federal Benefit Rate (FBR) › Meet all other non-financial requirements, such as: » Citizenship (U.S. citizen or qualified alien) » Being a Resident of Louisiana. ROW waiver opportunities may be offered for the following and based on the following priorities: Priority 1. The one-time transition of persons eligible for Developmental Disability (DD) services in either the Office of Aging and Adult Services (OASS) Community Choices Wavier (CCW) or the OAAS Adult Day Health Care Waiver (ADHC) to the ROW. Priority 2. Individuals living at Pinecrest Supports and Services Center or in a publicly operated Intermediate Care Facility for the Developmentally Disabled (ICF/DD) when Pinecrest was transitioned to a private ICF/DD through a Cooperative Endeavor Agreement (CEA) facility or alternate facilities. Alternates are defined as individuals living in a private ICF/DD who will give up the private ICF/DD bed to an individual living at Pinecrest or to an individual who was living in a publicly operated ICF/DD when it was transitioned to a private ICF/DD through a CEA facility.	**Housing Stabilization Service:** › Conduct a housing assessment identifying the participant's preferences related to housing and needs for support to maintain housing, budgeting for housing/living expenses, obtaining/accessing sources of income necessary for rent, home management, establishing credit, and understanding and meeting obligations of tenancy as defined in lease terms. › Assist participant to view and secure housing as needed, including arranging or providing transportation. Assist participant to secure supporting documents/records, completing/submitting applications, securing deposits, and locating furnishings. › Develop an individualized housing stabilization service provider plan based upon the housing assessment. › Participate in the development of the plan of care, incorporating elements of the housing stabilization service provider plan. › Participate in plan of care renewal and updates as needed. › Provide supports and interventions per the individualized housing stabilization service provider plan. › Communicate with the landlord or property manager regarding the participant's disability, accommodations needed, and components of emergency procedures involving the landlord or property manager. › If at any time the participant's housing is placed at risk (e.g., eviction, loss of roommate or income), provide supports to retain housing or locate and secure housing to continue community-based supports, including locating new housing or sources of income.

1915(c) HCBS Waivers				
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Louisiana Residential Options Waiver (ROW): 1915(c) HCBS Waiver			Individuals requesting to transition from Pinecrest are awarded a slot when one is requested, and their health and safety can be assured in an OCDD waiver. This also applies to individuals who were residing in a state-operated facility at the time the facility was privatized and became a (CEA) facility. Priority 3. Individuals on the registry who have the highest level of need and the earliest registry date shall be notified in writing when a funded OCDD waiver opportunity is available and that he/she is next in line to be evaluated for a possible waiver assignment. Priority 4. Individuals transitioning from ICF-ID facilities utilizing ROW Conversion Entrance to the ROW.	**Environmental Accessibility Adaptations:** Physical adaptations to the participant's primary residence which are necessary to ensure health, welfare, and safety to the participant, or which enable the participant to function with greater independence, without which the participant would require additional supports or institutionalization, including bathroom modifications, ramps, or other adaptations to make the home accessible to the participant. The service must be for a specific approved adaptation. **One-Time Transitional Service:** Non-reoccurring setup expenses to assist a participant who is moving from an institutional setting to their own home, including: › Non-refundable security deposits › Utility deposits › Bedroom furniture › Living room furniture › Tables and chairs › Window blinds › Kitchen items (e.g., food preparation items, eating utensils) › Moving expenses › Health and safety assurances (e.g., pest eradication, one-time cleaning prior to occupancy)

1915(c) HCBS Waivers				
State/Program Name	**Effective Dates**	**Target Population**	**Eligibility Criteria**	**Supportive Housing Benefits**
Wisconsin Self-Directed Support Waiver[2]	May 1, 2016 through April 20, 2021	Individuals 65+, Adults with developmental and/or intellectual disabilities (18+), and adults with physical disabilities (18-64) and institutional level of care	Eligible individuals must meet the following requirements: › Require nursing home level of care or intermediate level of care › Be one of the following: » Aged individual (65+) » Adult with developmental and/or intellectual disability (18+) » Adult with physical disability (18-64)	**Housing Counseling:** Comprehensive guidance on housing opportunities that are available to meet the participant's needs and preferences, including exploring both home ownership and rental options, and both individual and shared housing situations, including situations where the individual lives with his or her family. Housing counseling includes planning, guidance, and assistance in accessing resources related to: › Home ownership, both pre- and post-purchase › Home financing and refinancing › Home maintenance, repair, and improvements, including the abatement of environmental hazards › Rental counseling, not including cash assistance › Accessibility and architectural services and consultation › Weatherization evaluation and assistance in accessing these services › Lead-based paint abatement evaluation › Low-income energy assistance evaluation › Access to transitional or permanent housing › Accessibility inventory design › Health and safety evaluations of physical property › Debt/credit counseling › Homelessness and eviction prevention counseling › Identifying preferences of location and type of housing › Explaining the rights and responsibilities of a tenant with disabilities, including how to ask for reasonable accommodations and modifications › How to file a complaint

1915(c) HCBS Waivers				
State/Program Name	**Effective Dates**	**Target Population**	**Eligibility Criteria**	**Supportive Housing Benefits**
Wisconsin Self-Directed Support Waiver				**Home Modifications:** Services designed to assess the need for, arrange for, and provide modifications and/or improvements to a participant's non-rental residence that address a need identified to improve health, safety, accessibility, or provide for the maximization of independent functioning. This includes the cost of the permit to authorize the changes, materials, and services needed to complete the installation of specific equipment, the modification of the physical structure, or the reconfiguration of essential systems within the home. Home modifications are considered a one-time expense. Items considered portable (e.g., a portable ramp) are defined as adaptive aids. Home modifications may include adaptations, including, but not limited to: › Ramps (fixed), ramp extensions, and platforms › Porch/stair lifts › Doors/doorways, door handles/door opening devices › Adaptive door bells, locks/security items or devices › Plumbing, electrical modifications related to adaptations › Medically necessary heating, cooling, or ventilation systems › Shower, sink, tub, and toilet modifications › Faucets/water controls › Accessible cabinetry, counter tops, or work surfaces › Grab bars (see exception below), handrails, accessible closets › Smoke/fire alarms and fire safety adaptations › Adaptive lighting/light switches › Flooring and/or floor covering to address health and safety › Wall protection › Voice-, light-, or motion-activated devices that increase the participant's self-reliance and capacity to function independently

Overview of Select States Using 1915(i) State Plan Option to Offer Supportive Housing Benefits

1915(i) HCBS State Plan Amendments				
State/Program Name	**Effective Dates**	**Target Population**	**Eligibility Criteria**	**Supportive Housing Benefits**
Minnesota Housing Stabilization Services[3]	July 1, 2020 through June 30, 2023	Adults ages 18+ with a documented disability or disabling condition	A person is eligible for state plan HCBS if the person meets the following needs-based criteria: › The person is assessed to require assistance with at least one need in the following areas resulting from the presence of a disability and/or a long term or indefinite condition: » Communication » Mobility » Decision-making » Managing challenging behaviors › The person is experiencing housing instability, which is evidenced by one of the following risk factors: » Is homeless. An individual or family is considered homeless when they lack a fixed, adequate nighttime residence » Is at risk of homelessness. An individual or family is at risk of homelessness when (a) the individual or family is faced with a situation or set of circumstances likely to cause the household to become homeless, including, but not limited to: doubled-up living arrangements where the individual's name is not on a lease, living in a condemned building without a place to move, having arrears in rent/utility payments, receiving an eviction notice without a place to move and/or living in temporary or transitional housing that carries time limits; or (b) the person, previously homeless, will be discharged from a correctional, medical, mental health, or substance use disorder treatment center, lacks sufficient resources to pay for housing, and does not have a permanent place to live » Is currently transitioning, or has recently transitioned, from an institution or licensed/registered setting (registered housing with services facility, board and lodge, boarding care, adult foster care, hospital, ICF/DD, intensive residential treatment services, the Minnesota Security Hospital, nursing facility, regional treatment center).	**Housing Stabilization Service – Transition:** Community supports that help people plan for, find, and move to homes of their own in the community, including: › Supporting the person in applying for benefits to afford their housing › Identifying services and benefits that will support the person with housing instability › Assisting the person with the housing search and application process › Assisting the person with tenant screening and housing assessments › Helping a person understand and develop a budget › Helping recipients understand and negotiate a lease › Helping the recipient meet and build a relationship with a prospective landlord › Identifying resources to cover moving expenses › Helping the person arrange deposits › Ensuring the new living arrangement is safe and ready for move-in › Remote support when required to ensure the person's housing transition › Helping a person organize their move

1915(i) HCBS State Plan Amendments				
State/Program Name	**Effective Dates**	**Target Population**	**Eligibility Criteria**	**Supportive Housing Benefits**
Minnesota Housing Stabilization Services			**Target Group:** › These services will be provided to recipients who are 18 years and older and have a documented disability or disabling condition, defined as: › an individual who is aged, blind, or disabled as described under Title II of the Social Security Act; › a person diagnosed with an injury or illness that is expected to cause extended or long-term incapacitation; › a person who is diagnosed with a developmental disability (or related condition) or mental illness; › a person diagnosed with a mental health condition, substance use disorder, or physical injury that required a residential level of care, and who is now in the process of transitioning to the community; › a person who is determined by the lead agency, according to rules adopted by the Minnesota Department of Health, to have a learning disability; or › a person with a diagnosis of substance use disorder who is enrolled in a treatment program or is on a waiting list for a treatment program.	**Housing Stabilization Service – Sustaining:** Community supports that help a person to maintain living in their own home in the community, including: › Developing, updating, and modifying the housing support and crisis plan on a regular basis › Prevention and early identification of behaviors that may jeopardize continued housing › Education and training on roles, rights, and responsibilities of the tenant and property manager › Coaching to develop and maintain key relationships with property managers and neighbors › Advocacy with community resources to prevent eviction when housing is at risk › Assistance with the housing recertification processes › Continuing training on being a good tenant, lease compliance, and household management › Supporting the person to apply for benefits to retain housing › Supporting the person to understand and maintain income and benefits to retain housing › Supporting the building of natural housing supports and resources in the community › Remote support when required to help the person retain their housing Housing transition and housing sustaining services do not include: deposits, food, furnishings, rent, utilities, room and board, or moving expenses **Housing Consultation Services:** Planning services that are person-centered and assist a person with the creation of the person-centered plan. Recipients may also receive referrals to other needed services and supports based on the person-centered plan. The consultant monitors and updates the plan annually or more frequently if the person requests a plan change or experiences a change in circumstance. This service shall be separate and distinct from all other services and shall not duplicate other services or assistance available to the participant.

1915(i) HCBS State Plan Amendments				
State/Program Name	**Effective Dates**	**Target Population**	**Eligibility Criteria**	**Supportive Housing Benefits**
Texas HCBS Adult Mental Health (HCBS-AMH)[4]	September 1, 2015 through September 30, 2020	Adults ages 18+ with Serious Mental Illness (SMI)	An individual is eligible for State Plan HCBS under the HCBS-AMH program if the individual requires HCBS-AMH services to improve or maintain functioning, prevent relapse to a lower level of functioning, and maintain residence in the community. This need is determined through evaluation and reevaluation of functional need using a standardized instrument, the Adult Needs and Strengths Assessment (ANSA). Individuals must have a level of functional need (ANSA score of 2 or higher) that indicates a need for intervention provided by HCBS-AMH services that is identified by items in one of the following domains assessed by the ANSA: behavioral health, life domain functioning (including ADLs and IADLs), or functional needs and strengths. Need is also evidenced by at least one of the following: › A history of extended or repeated stay(s) in an inpatient psychiatric hospital (i.e., three years or more of consecutive or cumulative inpatient psychiatric hospitalization during the five years prior to initial enrollment in HCBS-AMH). Inpatient psychiatric criteria—which require that the individual be acutely ill and in need of 24-hour observation, stabilization, and intervention, including active supervision by a psychiatrist—are more stringent than HCBS needs-based criteria. However, individuals meeting an institutional level of care are not excluded from HCBS-AMH eligibility on that basis › Two or more psychiatric crises (i.e., inpatient psychiatric hospitalizations and/or outpatient psychiatric crises that meet inpatient psychiatric criteria) n the three years prior to initial enrollment in HCBS-AMH and four or more repeated discharges from correctional facilities › Two or more psychiatric crises (i.e., inpatient psychiatric hospitalizations and/or outpatient psychiatric crises that meet inpatient psychiatric criteria) in the three years prior to initial enrollment and 15 or more total emergency department (ED) visits	**Transition Assistance Services:** Set-up expenses for individuals transitioning from institutions into community settings. Allowable expenses are those necessary to enable individuals to establish basic households and may include: security deposits for leases on apartments or homes; essential household furnishings and expenses required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed and bath linens; set-up fees or deposits for utility or service access, including telephone, electricity, gas, and water; and services necessary for an individual's health and welfare, such as pest eradication and one-time cleaning prior to occupancy. TAS may also include services necessary for an individual's health and welfare, such as pest eradication and one-time cleaning prior to occupancy, and activities to assess need, arrange for, and procure needed resources (limited to up to 180 consecutive days prior to discharge). **Minor Home Modifications:** Minor home modifications are those physical adaptations to an individual's home that are necessary to ensure the individual's health, welfare, and safety, or that enable the individual to function with greater independence in the home. In order to receive minor home modifications under this program, the individual would require institutionalization without these adaptations. Adaptations may include widening of doorways, modification of bathroom facilities, installation of ramps, or other minor modifications which are necessary to achieve a specific rehabilitative goal defined in the Intensive Recovery Program (IRP) and prior approved by the Department of State Health Services (DSHS). Adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. are excluded from minor home modifications. Adaptations that add to the total square footage of the home are excluded from this benefit. Minor home modifications are not made to residential settings that are leased, owned, or controlled by service providers. All minor home modifications are provided in accordance with applicable state or local building codes.

1915(i) HCBS State Plan Amendments				
State/Program Name	**Effective Dates**	**Target Population**	**Eligibility Criteria**	**Supportive Housing Benefits**
Texas HCBS Adult Mental Health (HCBS-AMH)			**Target Group:** An adult over the age of 18 who meets the following criteria is eligible to receive State Plan HCBS: › Has a serious mental illness (SMI)—An illness, disease, disorder, or condition (other than a sole diagnosis of epilepsy, dementia, substance use disorder, or intellectual or developmental disability) that: » Substantially impairs an individual's thought, perception of reality, emotional process, development, or judgment; or » Grossly impairs an individual's behavior as demonstrated by recent disturbed behavior	

Overview of Select States Using 1115 Waivers to Offer Supportive Housing Benefits

1115 Waivers				
State/Program Name	**Effective Dates**	**Target Population**	**Eligibility Criteria**	**Supportive Housing Benefits**
Florida Behavioral Health and Supportive Housing Assistance Pilot[5]	**Demonstration Approval Period:** August 1, 2017 through June 30, 2022	Adults with a Serious Mental Illness (SMI), Substance Use Disorder (SUD), or SMI with co-occurring SUD who are currently homeless or at risk of homelessness	This pilot program is designed to provide necessary services for Florida Medicaid recipients ages 21 and older with an SMI, SUD, or an SMI with a co-occurring SUD who are homeless or at risk of homelessness due to their disability. The state will use the Department of Housing and Urban Development definition listed in 24 CFR 576.2 to determine risk of homelessness.	**Transitional Housing Services:** Services that support a recipient in the preparation for, and transition into, housing. This is an intensive service that includes activities such as conducting a tenant screening and housing assessment, developing an individualized housing support plan, assisting with the search for housing and the application process, identifying resources to pay for on-going housing expenses such as rent, and ensuring that the living environment is safe and ready for move-in. **Tenancy Sustaining Services:** Services that support a recipient in being a successful tenant. Tenancy support services include activities such as early identification and intervention for behaviors that may jeopardize housing such as late rental payment or other lease violations, education and training on the roles, rights, and responsibilities of the tenant and landlord, coaching on developing and maintaining key relationships with landlords/property managers, assistance (that may not include legal or financial assistance) in resolving disputes with landlords and/or neighbors to reduce risk of eviction, advocacy and linkage with community resources to prevent eviction, assistance with the housing assistance eligibility recertification process, and coordinating with the enrollee to review, update, and modify their housing support and crisis plans.
Hawaii Community Integration Services[6]	**Demonstration Approval Period:** August 1, 2019 through July 31, 2024	Chronically homeless adults/adults at risk of homelessness	**1.** Individuals are eligible if they meet at least one of the following health needs-based criteria and are expected to benefit from community integration services: › Individual is assessed to have a behavioral health need which is defined as one or both of the following criteria: » Mental health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support), resulting from the presence of a serious mental illness » Substance use need, where an assessment using American Society of Addiction Medicine (ASAM) criteria indicates that the individual meets at least ASAM level 2.1, indicating the need for outpatient day treatment for Substance Use Disorder (SUD) treatment › Individual assessed to have a complex physical health need, which is defined as a long continuing or indefinite physical condition requiring improvement, stabilization, or prevention of deterioration of functioning (including the ability to live independently without support)	**Pre-tenancy Supports:** › Conducting a functional needs assessment identifying the beneficiary's preferences related to housing and needs for support to maintain community integration; providing assistance in budgeting for housing and living expenses; › Assisting beneficiaries with connecting to social services to help with finding and applying for housing necessary to support the individual in meeting their medical care needs. › Developing an individualized plan based upon the functional needs assessment as part of the overall person centered plan. Identifying and establishing short and long-term measurable goal(s), and establishing how goals will be achieved and how concerns will be addressed. › Participating in person-centered plan meetings at redetermination and/or revision plan meetings, as needed › Providing supports and interventions per the person-centered plan

1115 Waivers

State/Program Name	Effective Dates	Target Population	Eligibility Criteria	Supportive Housing Benefits
Hawaii Community Integration Services			**2.** Individuals are eligible if they have at least one of the following risk factors: › Homelessness, defined as lacking a fixed, regular, and adequate nighttime residence, meaning one of the following: » Has a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground » Living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low income individuals) › At risk of homelessness, defined as an individual who will lose their primary nighttime residence, including when: » There is notification in writing that their residence will be lost within 21 days of the date of application for assistance; » No subsequent residence has been identified; and » The individual does not have sufficient resources or support networks, (e.g., family, friends, faith-based or other social networks) immediately available to prevent them from moving to or living in a place not meant for human habitation, a safe haven, or an emergency shelter › History of frequent and/or lengthy stays in a nursing facility » Frequent is defined as more than one contact in the past 12 months » Lengthy is defined as 60 or more consecutive days within an institutional care facility	**Tenancy Sustaining Services:** › Service-planning support and participating in person-centered plan meetings at redetermination and/or revision plan meetings, as needed › Coordinating and linking the recipient to services and service providers, including primary care and health homes; substance use treatment providers; mental health providers; medical, vision, nutritional, and dental providers; vocational, education, employment, and volunteer supports; hospitals and emergency rooms; probation and parole; crisis services; end-of-life planning; and other support groups and natural supports › Entitlement assistance, including assisting beneficiaries in obtaining documentation, navigating and monitoring application process, and coordinating with the entitlement agency **Community Transition Services Pilot Program:** *Transitional Case Management Services*: Services that will assist the individual with moving into stable housing, including assisting the individual in arranging the move, assessing the unit's and individual's readiness for move-in, and assisting the individual (excluding financial assistance) in obtaining furniture and commodities. *Housing Quality and Safety Improvement Services*: Repairs or remediation for issues such as mold or pest infestation if repair or remediation provides a cost-effective method of addressing occupant's health condition, as documented by a health care professional, and remediation is not covered under any other program. Modifications to improve accessibility of housing (e.g., ramps, rails) and safety (e.g., grip bars in bathtubs) when necessary to ensure occupant's health and modification are not covered under any other provision such as the Americans with Disabilities Act. *Legal Assistance*: Assisting the individual by connecting the enrollee to expert community resources to address legal issues affecting housing and thereby adversely affecting health, such as assistance with breaking a lease due to unhealthy living conditions. This pilot service does not include legal representation or payment for legal representation. *Securing House Payments*: Provide a one-time payment for security deposit and/or first month's rent provided that such funding is not available through any other program. This payment may only be made once for each enrollee during the life of the demonstration, except for state-determined extraordinary circumstances such as a natural disaster.

1115 Waivers				
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Maryland Assistance in Community Integration Services Pilot Program[7]	**Demonstration Approval Period:** January 1, 2017 through December 31, 2021	High-risk, high-utilizing Medicaid enrollees who are at risk of institutional placement or homelessness post-release from certain settings	Eligible individuals must meet the following: › Health criteria (at least one) » Repeated incidents of emergency department (ED) use (defined as more than four visits per year) and hospital admissions » Two or more chronic conditions as defined in Section 1945(h)(2) of the Social Security Act › Housing Criteria (at least one) » Individuals who will experience homelessness upon release from the settings defined in 24 CFR 578.3 » Those at imminent risk of institutional placement	**Tenancy-Based Case Management:** Assist the target population in obtaining the services of state and local housing programs to locate and support the individual's medical needs in the home These services may include: › Conducting a community integration assessment identifying the participant's preferences related to housing and needs for support to maintain community integration, assistance in budgeting for housing/living expenses, assistance in connecting the individual with social services to assist with filling out applications and submitting appropriate documentation in order to obtain sources of income necessary for community living and establishing credit, and understanding and meeting obligations of tenancy › Assisting individuals to connect with social services to help with finding and applying for housing necessary to support the individual in meeting their medical care needs, including arranging for or providing transportation for services provided in the plan of care › Developing an individualized community integration plan based upon the assessment as part of the overall person-centered plan › Providing supports and interventions per the person-centered plan (individualized community integration portion) › Providing supports to assist the individual in communicating with the landlord and/or property manager regarding the participant's disability (if authorized and appropriate), detailing accommodations needed and addressing components of emergency procedures involving the landlord and/or property manager › Coordinating with the tenant to review, update, and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers › Connecting the individual to training and resources that will assist the individual in being a good tenant and lease compliant, including ongoing support with activities related to household management

1115 Waivers

State/Program Name	Effective Dates	Target Population	Eligibility Criteria	Supportive Housing Benefits
Maryland Assistance in Community Integration Services Pilot Program				**Housing Case Management Services:** › Service-planning support and participating in person-centered plan meetings at redetermination and/or revision plan meetings as needed › Coordinating and linking the recipient to services, including primary care and health homes; substance use treatment providers; mental health providers; medical, vision, nutritional, and dental providers; vocational, education, employment, and volunteer supports; hospitals and emergency rooms; probation and parole; crisis services; end-of-life planning; and other support groups and natural supports. › Entitlement assistance, including assisting individuals in obtaining documentation, navigating and monitoring application process, and coordinating with the entitlement agency › Assistance in accessing supports to preserve the most independent living, including skills coaching, financial counseling, anger management, individual and family counseling, support groups, and natural supports.
Massachusetts MassHealth Accountable Care Organization (ACO) and Community Partner Flexible Services Program	**Demonstration Approval Period:** July 1, 2017 through June 30, 2022	MassHealth member enrolled in a participating ACO who meets ACO-developed target criteria	ACO member with one or more health needs-based criteria: › The individual is assessed to have a behavioral health need (a mental health or substance use disorder such as depression or bipolar disorder) requiring improvement, stabilization, or prevention of deterioration of functioning (including the ability to live independently without support) › The individual is assessed to have a complex physical health need, which is defined as a persistent, disabling, or progressively life-threatening physical health condition(s) (e.g., diabetes, hypertension) requiring improvement, stabilization, or prevention of deterioration of functioning (including the ability to live independently without support) › The individual is assessed to have a need for assistance with one or more Activities of Daily Living or Instrumental Activities of Daily Living › The individual has repeated incidents of emergency department use (defined as two or more visits within six months, or four or more visits within a year)	**Pre-Tenancy Supports – Individual Supports:** › Assessing and documenting the member's preferences related to the tenancy the member seeks, including the type of rental sought, the member's preferred location, the member's roommate preference (and, if applicable, the identification of one or more roommates), and the accommodations needed by the member › Assisting the member with budgeting for tenancy/living expenses, and assisting the member with obtaining discretionary or entitlement benefits and credit (e.g., completing, filing, and monitoring applications to obtain discretionary or entitlement benefits and credit as well as obtaining or correcting the documentation needed to complete such applications) › Assisting the member with obtaining, completing, and filing applications for community-based tenancy › Assisting the member with understanding their rights and obligations as tenants › Assisting the member with obtaining services needed to establish a safe and healthy living environment › Assisting or providing the member with transportation to any of the approved pre-tenancy supports when needed

1115 Waivers

State/Program Name	Effective Dates	Target Population	Eligibility Criteria	Supportive Housing Benefits

Massachusetts
 	
MassHealth Accountable Care Organization (ACO) and Community Partner Flexible Services Program[8]
			• The individual is pregnant and experiencing high-risk pregnancy or complications associated with pregnancy including individuals who:
			  » Are 60 days postpartum;
			  » Have children up to one year of age
			  » Have children born of the pregnancy up to one year of age.
			• The member must also meet at least one of three risk factors:
			  » Experiencing homelessness
			  » At risk of experiencing homelessness
			  » At risk for nutritional deficiency or imbalance due to food insecurity
			• Members also will have to meet ACO-specific target criteria.
				Pre-Tenancy Supports – Transitional Assistance: Assisting the member with obtaining and/or providing the member with one-time household setup costs and move-in expenses including, but not limited to:
				• First and last month's rent
				• Security deposit
				• Back utilities
				• Utility deposits (e.g., electricity, gas, heating fuel, water, sewer)
				• Costs for filing applications
				• Obtaining and correcting needed documentation
				• Purchase of household furnishings needed to establish community-based tenancy
				Tenancy Sustaining Supports:
				• Assisting the member with communicating with the landlord and/or property manager regarding the member's disability and detailing the accommodations needed by the member
				• Assisting the member with the review, update, and modification of the member's tenancy support needs, as documented in the member's Flexible Services (FS) Plan, on a regular basis to reflect current needs and address existing or recurring barriers to retaining community tenancy
				• Assisting the member with obtaining and maintaining discretionary or entitlement benefits and establishing credit, including, but not limited to, obtaining, completing, filing, and monitoring applications
				• Assisting the member with obtaining appropriate sources of tenancy training, including trainings regarding lease compliance and household management
				• Assisting the member in all aspects of the tenancy, including, when needed, legal advocacy (in the form of coaching, supporting, and educating the member) during negotiations with a landlord, and directing a member to appropriate sources of legal services
				• Assisting the member with obtaining or improving the adaptive skills needed to function and live independently and safely in the community and/or family home, including advising the member of the availability of community resources

1115 Waivers

State/Program Name	Effective Dates	Target Population	Eligibility Criteria	Supportive Housing Benefits
Massachusetts MassHealth Accountable Care Organization (ACO) and Community Partner Flexible Services Program				› Assisting or providing the member with transportation to any of the tenancy sustaining supports when needed **Home Modifications:** Limited physical adaptations to the member's community-based dwelling when necessary to ensure the member's health, welfare, and safety, or to enable the member to function independently in a community-based setting. These may include, but are not limited to: › Installation of grab bars and hand showers › Doorway modifications › In-home environmental risk assessments › Refrigerators for medicine such as insulin › High efficiency particulate air (HEPA) filters › Vacuum cleaners › Pest management supplies and services › Air conditioner units › Hypoallergenic mattresses and pillow covers › Traction or non-skid strips › Night lights › Training to use such supplies and modifications correctly
North Carolina Healthy Opportunities Pilots[9,10]	**Demonstration Approval Period:** November 1, 2019 through October 31, 2024	High-risk Medicaid adults, pregnant women, and children who meet certain social risk factors	Beneficiaries must have at least one physical/behavioral condition and one social risk factor to be considered eligible: **Physical/Behavioral Risk Need-Based Criteria:** *Adults (22+)* › Two or more chronic conditions. Chronic conditions that qualify an individual for Pilot enrollment include: Body Mass Index (BMI) over 25, blindness, chronic cardiovascular disease, chronic pulmonary disease, congenital anomalies, chronic disease of the alimentary system, substance use disorder, chronic endocrine and cognitive conditions, chronic musculoskeletal conditions, chronic neurological disease, and chronic renal failure, in accordance with Social Security Act section 1945(h)(2). › Repeated incidents of emergency department use (defined as more than four visits per year) or hospital admission	**Housing Navigation, Support, and Sustaining Services:** Provision of one-to-one case management and/or educational services to prepare an enrollee for stable, long-term housing (e.g., identifying housing preferences and developing a housing support plan), and to support an enrollee in maintaining stable, long-term housing (e.g., development of independent living skills, ongoing monitoring, and updating of housing support plan). Various activities are included within this service. **Inspection for Housing Safety and Quality:** A housing safety and quality inspection by a certified professional includes assessment of potential home-based health and safety risks to ensure living environment is not adversely affecting occupants' health and safety. Inspections may assess the habitability and/or environmental safety of an enrollee's current or future dwelling.

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State/Program Name	**Effective Dates**	**Target Population**	**Eligibility Criteria**	**Supportive Housing Benefits**
North Carolina Healthy Opportunities Pilots			*Pregnant Women* › Multifetal gestation › Chronic condition likely to complicate pregnancy, including hypertension and mental illness › Current or recent (month prior to learning of pregnancy) use of drugs or heavy alcohol › Adolescent 15 years of age or less › Advanced maternal age, 40 years of age or more › Less than one year since last delivery › History of poor birth outcome, including: preterm birth, low birthweight, fetal death, and neonatal death *Children (0-3)* › Neonatal intensive care unit graduate › Neonatal Abstinence Syndrome › Prematurity, defined by births that occur at or before 36 completed weeks gestation › Low birth weight, defined as weighing less than 2,500 grams (five pounds and eight ounces) upon birth › Positive maternal depression screen at an infant well-visit *Children (0-21)* › One or more significant uncontrolled chronic conditions or one or more controlled chronic conditions that have a high risk of becoming uncontrolled due to unmet social need, including: asthma, diabetes, underweight or overweight/obesity as defined by having a BMI of less than the 5th or greater than the 85th percentile for age and gender, developmental delay, cognitive impairment, substance use disorder, behavioral/mental health diagnosis (including a diagnosis under Diagnostic Code: 0-5), attention-deficit/hyperactivity disorder, and learning disorders	**Housing Move-In Support:** Non-recurring setup expenses. Allowable expenses include, but are not limited to, moving expenses required to occupy and utilize the housing (e.g., moving service to transport an individual's belongings from current location to new housing/apartment unit, delivery of new or used furniture, etc.), nonrefundable utility setup costs for utilities essential for habitable housing (e.g., initial payments/deposits to activate heating, electricity, water, and gas), and discrete goods (e.g., essential furnishings, bedding, basic kitchen utensils) to support an enrollee's transition to stable housing as part of this service. **Reinstatement of Essential Utilities:** Nonrecurring payment to resolve arrears related to unpaid utility bills and cover nonrefundable utility setup costs to restart the service if it has been discontinued in a Pilot enrollee's home, putting the individual at risk of homelessness or otherwise adversely affecting their health (e.g., in cases when medication must be stored in a refrigerator). This service may be used in association with essential home utilities that have been discontinued (e.g., initial payments to activate heating, electricity, water, and gas). **Home Remediation Services:** Services to eliminate known home-based health and safety risks to ensure living environment is not adversely affecting occupants' health and safety. Home remediation services may include pest eradication, mold removal, installation of washable curtains or synthetic blinds to prevent allergens, or lead abatement. **Home Accessibility and Safety Modifications:** Services to eliminate known home-based health and safety risks to ensure living environment is not adversely affecting occupants' health and safety. Home accessibility modifications are adjustments to homes that need to be made in order to allow for enrollee mobility, enable independent living, and accommodate medical equipment and supplies. Home modifications should improve the accessibility and safety of housing (e.g., installation of entrance ramps, hand-held shower controls, nonslip surfaces, grab bars in bathtubs, and reparation of cracks in floor).

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State/Program Name	Effective Dates	Target Population	Eligibility Criteria	Supportive Housing Benefits
North Carolina Healthy Opportunities Pilots			Social Risk Factors › Homelessness and Housing Insecurity: Homelessness, as defined in 42 C.F.R. § 254b(h)(5)(A), and housing insecurity, as defined based on questions used to establish housing insecurity in the Accountable Health Communities Health Related Screening Tool. › Food Insecurity: As defined by the U.S. Department of Agriculture-commissioned report on Food Insecurity in America: » Low Food Security: reports of reduced quality, variety, or desirability of diet. Little or no indication of reduced food intake » Very low food security: Reports of multiple indications of disrupted eating patterns and reduced food intake › Transportation Insecurity: Defined based on questions used to establish transportation insecurities in the Accountable Health Communities Health Related Screening Tool › At risk of, witnessing, or experiencing interpersonal violence: Defined based on questions used to establish interpersonal violence in the Accountable Health Communities Health Related Screening Tool.	**Healthy Home Goods:** Goods furnished to eliminate known home-based health and safety risks to ensure living environment is not adversely affecting occupants' health and safety. Home-related goods that may be covered include, for example, discrete items related to reducing environmental triggers in the home (e.g., a "Breathe Easy at Home Kit" with Environmental Protection Agency (EPA) certified-vacuum, air filter, green cleaning supplies, air conditioners, hypoallergenic mattress or pillow covers, or nontoxic pest control supplies). **One-Time Payment for Security Deposit and First Month's Rent**: Provision of a one-time payment for an enrollee's security deposit and first month's rent to secure affordable and safe housing that meets the enrollee's needs. **Short-Term Post-Hospitalization Housing:** Post-hospitalization housing for short-term period, not to exceed six months, due to individual's imminent homelessness at discharge. Housing should provide enrollees with a safe space to recuperate and perform activities of daily living while receiving ongoing medical care as needed and will be limited to permanent housing in a private or shared housing unit.
Washington Foundational Community Supports (FCS)[11,12]	**Demonstration Approval Period:** January 9, 2017 through December 31, 2021		Eligible populations must be 18 or older, meet one physical/behavioral needs-based factor, and have at least one risk factor, including: › Chronic homelessness (as defined by the U.S. Department of Housing and Urban Development)[13] › Frequent (more than one contact in the past 12 months) or lengthy (more than 90 days) institutional contacts › Frequent stays in adult residential care (more than one contact in the past 12 months) › Frequent turnover of in-home caregivers (use of three or more different in-home caregiver provider agencies in 12 months) › PRISM (Predictive Risk Information SysteM) risk score of 1.5 or above	**Pre-Tenancy Supports:** › Conducting a functional needs assessment identifying the enrollee's preferences related to housing › Assisting individuals to connect with social services to help with finding and applying for housing necessary to support the individual in meeting their medical care needs › Developing an individualized community integration plan based on the functional need assessment as part of the overall person-centered plan › Identifying and establishing short- and long-term measurable goal(s), how goals will be achieved, and how concerns will be addressed › Participating in person-centered plan meetings at redetermination and/or revision plan meetings as needed › Providing supports and interventions per the person-centered plan

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State/Program Name	**Effective Dates**	**Target Population**	**Eligibility Criteria**	**Supportive Housing Benefits**
			Beneficiaries must also have a: › Mental health need where there is a need for improvement, stabilization, or prevention of deterioration of functioning resulting from the presence of mental illness › Need for outpatient substance use disorder treatment › Need for assistance with three or more activities of daily living › Need for hands-on assistance with one or more activities of daily living › Complex physical health need—a long continuing or indefinite physical condition requiring improvement, stabilization, or prevention of deterioration of functioning, including the ability to live independently without support	**Tenancy Sustaining Services:** › Providing service-planning support and participating in person-centered plan meetings at redetermination and/or revision plan meetings as needed › Coordinating and linking the recipient to services, including primary care and health homes; substance use treatment providers; mental health providers; medical, vision, nutritional, and dental providers; vocational, education, employment, and volunteer supports; hospitals and emergency rooms; probation and parole; crisis services; end-of-life planning; other support groups; and natural supports › Providing entitlement assistance, including obtaining documentation, navigating and monitoring the application process, and coordinating with the entitlement agency › Assisting with accessing supports to preserve the most independent living, such as individual and family counseling, support groups, and natural supports › Providing supports to assist the individual in the development of independent living skills, such as skills coaching, financial counseling, and anger management › Providing support to assist the individual in communicating with the landlord and/or property manager regarding the participant's disability (if authorized and appropriate), detailing accommodations needed, and addressing components of emergency procedures involving the landlord and/or property manager › Coordinating with the tenant to review, update, and modify his or her housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers › Connecting the individual to training and resources that will assist the individual in being a good tenant and lease compliant, including ongoing support with activities related to household management

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ABOUT MANATT HEALTH

This document was prepared by Stephanie Anthony, Patricia Boozang, and Mandy Ferguson. Manatt Health integrates legal and consulting expertise to better serve the complex needs of clients across the healthcare system. Our diverse team of more than 160 attorneys and consultants from Manatt, Phelps & Phillips, LLP and its consulting subsidiary, Manatt Health Strategies, LLC, is passionate about helping our clients advance their business interests, fulfill their missions, and lead healthcare into the future. For more information, visit ***https://www.manatt.com/Health***.

Endnotes

1. Louisiana Residential Options Waiver (o472.Ro2.00). Available at: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=8468

2. Wisconsin Self-Directed Support Waiver-DD. 1915(c) Waiver Approval. Centers for Medicare and Medicaid. Available at: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=8667

3. Minnesota SPA 18-0008 – Housing Stabilization Services in the State Plan under the authority of Section 1915(i) of the Social Security Act. Available at: https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MN/MN-18-0008.pdf

4. Texas SPA 14-0014. Available at: https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/behavioral-health-provider/hcbs-amh/hcbs-amh-medicaid-state-plan.pdf. As amended by SPA 16-001. Available at: https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/TX/TX-16-0001.pdf

5. Florida Managed Medical Assistance (MMA) 1115 Demonstration Waiver Approval. Centers for Medicare and Medicaid Services. Available at: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=8450

6. Hawaii QUEST Integration 1115 waiver extension Approval Letter. Centers for Medicare and Medicaid Services. July 31, 2019. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/hi/hi-quest-expanded-ca.pdf

7. Maryland Health Choice 1115 Waiver. Centers for Medicare and Medicaid Services. March 18., 2019. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/md/md-healthchoice-ca.pdf

8. Massachusetts MassHealth 1115 Demonstration Waiver. Available at: https://www.mass.gov/service-details/1115-masshealth-demonstration-waiver; MassHealth Flexible Services Guidance. Available at: https://www.mass.gov/doc/flexible-services-guidance-document/download

9. North Carolina's Medicaid Reform Demonstration: Approval Letter. Centers for Medicare and Medicaid Services. Oct. 19. 2018. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nc/nc-medicaid-reform-ca.pdf

10. North Carolina's housing-related service descriptions are draft descriptions as of July 15, 2019, when North Carolina DHHS released them for public comment. These descriptions and are subject to change based on stakeholder feedback and CMS review approval. Available at: https://files.nc.gov/ncdhhs/documents/Public-Feedback-Pilot-Service-Definitions-and-Pricing-Inputs-FULL-PACKAGE-FINAL.pdf

11. Washington Medicaid Transformation Project Waiver Approval. Centers for Medicare and Medicaid. Jan. 9, 2017. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wa/wa-medicaid-transformation-ca.pdf

12. Amerigroup. Supplemental Provider Manual: Foundational Community Supports. Available at: https://providers.amerigroup.com/documents/WAWA_TPA_ProviderManual.pdf

13. HUD Definition of Homelessness: Defined to mean an individual lives either in a place not meant for human habitation, a safe haven, in an emergency shelter, or in an institutional care facility if the individual has been living in the facility for fewer than 90 days and had been living in a place not meant for human habitation, a safe haven, or in an emergency shelter immediately before entering the institutional care facility. In order to meet the "chronically homeless" definition, the individual also must have been living as described above continuously for at least 12 months, or on at least four separate occasions in the last three years, where the combined occasions total a length of time of at least 12 months.