DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CENTERS FOR MEDICARE & MEDICAID SERVICES
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State Demonstrations Group

January 6, 2025

Cynthia Beane
Commissioner
Bureau for Medical Services
West Virginia Department of Human Services
350 Capitol St., Room 251
Charleston, WV 25301

Dear Commissioner Beane:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of the Health-Related Social Needs (HRSN) services protocol for the Evolving West Virginia Medicaid's Behavioral Health Continuum of Care section 1115(a) demonstration (Project Number 11-W-00307/3). We have determined the services protocol is consistent with the requirements outlined in the demonstration Special Terms and Conditions (STCs) and are therefore approving it. A copy of the approved protocol is enclosed and will be incorporated into the STCs as Attachment J.

We look forward to our continued partnership on the Evolving West Virginia Medicaid's Behavioral Health Continuum of Care section 1115(a) demonstration. If you have any questions, please contact your project officer, Jamie John at Jamie.John@cms.hhs.gov.

Sincerely,

Angela D. Garner -S

Digitally signed by Angela D. Garner -S
Date: 2025.01.06 11:51:01 -05'00'

Angela D. Garner
Director
Division of System Reform Demonstrations
State Demonstrations Group

Enclosure

cc: Nicole Guess, State Monitoring Lead, Medicaid and CHIP Operations Group

West Virginia (WV) Bureau for Medical Services (BMS): Health-Related Social Needs (HRSN) Services Protocol

Protocol for HRSN Services: In accordance with the WV 1115 waiver renewal STCs, this protocol provides additional detail on the requirements for delivery of HRSN services under the WV 1115 waiver program. In the context of this 1115 waiver, services associated with the HRSN framework are supported housing services. The HRSN Protocol outlines:

- Populations eligible and the process/criteria for identifying eligible individuals;
- Eligible HRSN providers and associated qualifications;
- HRSN supported housing services covered as part of WV BMS' 1115 waiver;
- A description of the HRSN care planning process driven by an assessment of need; and
- Additional agreements as related to HRSN service delivery, monitoring, and evaluation.

Please note: Infrastructure funding will not be addressed in this protocol as WV BMS has not requested infrastructure funding to support HRSN services implementation. The Centers for Medicare & Medicaid Services (CMS) team has acknowledged that given this decision, an infrastructure protocol is not required of the State.

I. Member Eligibility – Identifying Members with SUD and HRSN

Covered Population

The following population will be eligible to receive HRSN services under the 1115 demonstration provided that the individuals also satisfy the applicable clinical and social risk criteria and that supported housing services are determined to be medically necessary:

Table 1: Population Eligible for Supported Housing Services

Population	Description
Adults with SUD who are homeless or at risk of homelessness	The covered population includes individuals who meet the following criteria: • Adults 18 years old or older; and • Diagnosed with a SUD; and • Homeless or at risk of homelessness as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5 except for the annual income requirement in 24 CFR 91.5 (1)(i).

Identifying Beneficiaries With HRSN

Beneficiary Qualifications: To ensure the services are medically appropriate, the State will require that individuals meet the clinical and social risk criteria documented in Table 2 below, in addition to the criteria for the covered population in Table 1.

Implementation Settings: HRSN supported housing services will be provided by qualified healthcare professionals at Licensed Behavioral Health Centers (LBHCs), including Certified Community Behavioral Health Clinics (CCBHCs), and Comprehensive Behavioral Health

Centers. To support the needs of this population, services may take place in the office or in community settings. Individuals may be identified and referred to the LBHC for HRSN intake and assessment through a number of channels, including self-referral, other community behavioral and physical health organizations, Medicaid managed care organizations, and other community partners, including state and local housing agencies.

Screening: The State will provide a template to support intake, screening, documentation of all criteria, and determination of medical appropriateness. The template may include information from the member, health and behavioral health care providers, Medicaid MCOs, and information provided by community partners that documents current housing status and other criteria. Screening to determine eligibility for HRSN supported housing services will be conducted and documented. Individuals will be screened and assessed for both clinical and social risk factors to inform whether supported housing services are medically appropriate to address their needs, including how supported housing will support recovery, address related health and behavioral health needs, and minimize or avoid inappropriate use of medical resources.

As part of a comprehensive intake process, an individual's social risk factors and needs will be assessed using standardized HRSN screening tools such as the CMS Accountable Health Communities HRSN Screening Tool or the Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences (PRAPARE) Screening Tool. Based on an individual's SUD diagnosis in conjunction with consideration of clinical and social risk factors, documented health and social information, a provider will deem supported housing services medically appropriate.

The provider will identify the specific housing supports that are medically appropriate, including frequency, duration, and amount. The request for supported housing services will be subject to a review and approval process by the State and/or applicable MCO or utilization review contractor. Once approved, the provider is expected to make a referral, and where possible a warm hand-off, to supported housing services as specified.

Care planning is discussed in more detail below in this Protocol. Any rescreening or reassessment of needs will be driven by the individual's care plan and conducted according to and as part of the care plan review cadence, but no less than annually.

Table 2: Risk Factors Indicating Medical Appropriateness

Criteria Type and Number	Description
Clinical Risk Factor	The individual has a SUD diagnosis and high utilization of inpatient and/or outpatient services as a result of their SUD diagnosis. This clinical risk could be indicated by frequent Emergency Department (ED) or inpatient stays. "Frequent" would be defined as more than four ED visits and/or hospitalizations in the past year, or more than one inpatient stay in the same timeframe.

Social Risk Factor	The individual is experiencing homelessness (i.e., lacking a fixed, regular, and adequate nighttime residence), is at risk of homelessness (i.e., at risk of losing their primary nighttime residence). "Homelessness" and "at risk of homelessness" are further defined in accordance with definitions specified in 24 CFR 91.5, except for the annual income requirement in 24 CFR 91.5 (1)(i)".

BMS will maintain, on the public facing BMS website, references to both clinical and social risk factors and associated criteria an individuals must meet to be eligible. The State will also provide awareness on where the public may find additional information about criteria and assessment tools used, including relevant resources or links to resources as applicable. The content will be updated if related criteria is updated.

II. Provider Qualifications and Requirements

Organizational Provider Agencies

Provider agencies offering supported housing must have a current State of WV Behavioral Health License issued by the WV Department Human Services (DoHS) Office of Health Facility and Certification (OHFLAC) and must be an enrolled Medicaid provider also approved as an 1115 waiver Behavioral Health provider. Providers must obtain BMS authorization to provide supported housing services.

Individual Providers, Training, and Supervision

Individual providers delivering supported housing services must, at a minimum, have a bachelor's degree in a Human Services field and have knowledge of principles, methods, and procedures related to supported housing service activities meant to support an individual's ability to obtain and maintain housing stability and recovery goals. Staff should additionally have at least one year or relevant professional experience and/or training in the field of service. Relevant experience and/or training will be interpreted broadly. Providers must be Medicaid-enrolled to bill BMS for services delivered.

Providers delivering supported housing services are to be trained in accordance with evidence-based supported housing principles and practices. These staff must be overseen by appropriately certified and/or licensed supervisors. Contracted providers must assure that staff providing supported housing services maintain required qualifications to effectively serve members.

Service providers for supported housing services will be required to meet the following additional qualifications and/or requirements:

- Demonstrate the capacity and experience to provide HRSN housing services through knowledge of principles, methods, and procedures of housing services covered under the 1115 waiver, or comparable services meant to support individuals in obtaining and maintaining stable housing.

- Housing services providers are expected to meet qualifications that ensure they can provide high-quality services to eligible members as well as have culturally specific expertise to connect with members of the SUD and/or housing unstable population. Qualifications may include, for example:

    a. Maintaining sufficient hours of operation and staffing to serve the needs of HRSN participants receiving supported housing services.

    b. Demonstrate capabilities and/or experience with effectively serving individuals with SUD, as well as knowledge and/or experience working with individuals with housing or other HRSN needs. HRSN providers may demonstrate these capabilities and/or experience through, for example:

        - Submitting an annual report or similar document that describes the HRSN Provider's relevant capabilities, knowledge, experience, and/or activities.

        - Demonstrate that the entity has qualified service delivery and administrative staff to provide supported housing services, as determined at State discretion.

        - Other methods as determined sufficient by the State.

    c. The ability to comply with applicable federal and state laws. This will include, but not be limited to, 1115 waiver requirements for service provision.

    d. The capacity to provide culturally and linguistically appropriate, responsive, and trauma-informed service delivery, including by ensuring their ability to:

        - Adhere to federal and state laws and requirements related to ensuring communication and delivery of services to members with diverse cultural and ethnic backgrounds.

        - Meet cultural needs of the community for whom it provides services.

        - Provide documentation of how cultural responsiveness and trauma-informed care trainings are impacting organizational policies and staff practices.

        - Document efforts to recruit and employ staff who reflect the HRSN providers' region's Medicaid population, including individuals with similar demographics, lived experience, background and/or language fluency as possible.

The State and supporting partner entities in the fee for service and managed care delivery systems will work to ensure that HRSN service providers meet and maintain compliance with the minimum qualification requirements as specified above.

III. HRSN Services – Service Definitions of Covered Supported Housing Services

The State will cover HRSN supported housing service components as defined in Table 3 below. For documentation of specific provider qualifications for provision of these services, please refer to **Section II** above, specifically the subsection 'Individual Providers, Training, and Supervision.'

Table 3: WV Supported Housing Services

Service Component	Service Description
Pre-Tenancy Services	Pre-tenancy and housing navigation services are supports to individuals to achieve their stability goals, as defined by the individual. These case management/coordination-like services include: 1. Working with the individual to develop a housing plan that supports the stated needs of the member to achieve their housing stability goals; 2. Reviewing, updating, and modifying the plan with the member to reflect current needs and preferences and address existing or recurring housing retention barriers; 3. Searching for housing and presenting options; 4. As needed, facilitating coordination with and linkage to the local Continuum of Care for housing; 5. Assisting in completing housing applications and payment of any housing application or inspection fees; 6. Assisting in coordinating transportation to ensure access to housing options prior to transition and on move-in day; 7. Ensuring that the living environment is safe and ready for move-in; 8. Assisting in arranging for and supporting the details of the move; 9. Engaging the landlord and communicating with and advocating on behalf of the member with landlords; 10. Assist the member in communicating with the landlord and property manager;

	11. Providing training and resources to assist the member in complying with the member's lease; 12. Establishing procedures and contacts to retain housing, including developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized; 13. Providing supports to assist the member in the development of independent living skills needed to remain housed (e.g., skills to maintain a healthy living environment, develop and manage a household budget, interact appropriately with neighbors or roommates, reduce social isolation, utilize local transportation, etc.); and/or 14. Coordinating referrals for access to additional necessary medical, disability, social, educational (including college or higher education), legal, income-related tools and resources for housing, and other services.
Housing Transition Supports (Transition Costs)	One-time transition and moving costs necessary to navigate the transition to housing and establish a basic household such as: 1. Deposits needed to secure housing (i.e., security deposits); 2. Utility set-up fees/deposits and up to six months of unresolved utility arrearages if necessary to set up services in new residence; and first month coverage of utilities, including water, garbage, sewage, recycling, gas, electric, internet and phone (inclusive of land line phone service and cell phone service). Payment in arrears cannot exceed 6 months. The combination of arrears payments and prospective payments cannot exceed 6 months; 3. Relocation expenses; these include movers, pest eradication, application and inspection fees, one-time move-in fees or other associated fees required by the landlord for occupancy, packing materials and supplies. 4. Pantry stocking at move in, up to 30 days of food; 5. Basic household goods and furniture, which may include appliances necessary for food consumption, bedding, furnishings, cribs, bathroom supplies, and cleaning supplies.
Tenancy – Sustaining Services	These services are intended to assist individuals in maintaining housing stability. These case management/coordination-like services may include:

	1. Engaging the landlord and communicating with and advocating on behalf of the member with landlords; 2. Providing supports to assist the member in communicating with the landlord and property manager; 3. Providing training and connections to resources to assist the member in complying with the member's lease; 4. Establishing procedures and contacts to retain housing, including reviewing and updating a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized; 5. Assist the member in the development of independent living skills needed to remain housed (e.g., skills to maintain a healthy living environment, develop and manage a household budget, maintain relationships with neighbors or roommates, reduce social isolation, utilize local transportation, connect to needed behavioral health or other healthcare services, peer mentors or social supports, etc.); and/or 6. Coordinating referrals for other necessary medical, social, educational (including college or higher education), legal, and additional services (e.g., connections to behavioral health treatment providers).

IV. HRSN Plan of Care and Care Planning Process

The successful outcome of supported housing services is that an individual obtains, transitions to, and maintains decent and affordable community-based housing determined by individual choice and the assessment of need. Services provided will be in response to a specific goal in the member's plan of care.

As mentioned above in **Section I**, qualified healthcare providers will document findings from assessments and screenings determining SUD diagnosis as well as an individual's housing/HRSN needs in alignment with criteria specified above. For individuals determined eligible for supported housing services, any assessment results, screening results, and/or associated next steps must be documented in the individual's plan of care (i.e., care plan, treatment plan).

The individual's care plan must be based on an assessment of the individual's needs in conjunction with their goals, objectives, and preferences. Goals written into the care plan should address problems identified in the assessment and/or screening processes, such as lack of housing, and include specific objectives related to the problem's resolution. Specifically, the plan will include at a minimum:

- The recommended HRSN service component(s);

- The anticipated service duration;
- The determination that the recommended service, unit of service, and service duration is medically appropriate based on clinical and social risk factors;
- The goals of the service(s);
- The follow-up and transition plan;
- The provider or care management team responsible for managing the member's HRSN services.

The care plan must be developed collaboratively between the provider and the individual receiving HRSN services and must be a flexible document that can be modified according to review cadence as well as an individual's specific needs or circumstances. A plan of care for supported housing services may be incorporated into an individual's existing treatment plan, if applicable.

The provider is required to have at least one meeting with the individual, either in person or by telephone or videoconference during the development of the care plan. If efforts to have a meeting are unsuccessful, the provider is required to document connection attempts, barriers to having a meeting, and justification for continued provision of service.

Any rescreening or reassessment of HRSN supported housing needs will be driven by goals and objectives within the individual's care plan and conducted according to the care plan review cadence. Supported housing care plan reviews should occur every 90 days, or at a critical juncture if warranted.

Referrals to Community Partners

An individual's care plan will provide resources for and/or referrals to additional social service providers and/or community supports in an individual's geographic area, to help ensure a holistic approach to care and services.

HRSN service providers will be encouraged to utilize a closed-loop referral process to other social service providers and community partners. This process would help directly refer individuals to other services they may be eligible for based on screening outcomes. The closed-loop referral process would also help ensure partnering entities have relevant data readily accessible.

The state will collaborate with community-based organization and other community partners on an approach to data sharing that meets entities where they are today and supports movement toward uptake and the use of shared systems, such as those that support closed-loop referrals.

The state will also require managed care organizations to support and incentivize HRSN providers to implement closed-loop referral processes and explore adoption of technology to support these processes.

Expectations for Culturally Responsive and/or Trauma-Informed Care

HRSN supported housing services, as well as screenings conducted to assess need for these services, must be provided in a manner that is culturally responsive and/or trauma-informed as applicable, to ensure the member's safety and comfort in the environment where screenings are done and/or services are provided.

Providers of supported housing services must meet specific qualifications, including those related to culturally responsive and trauma-informed care. Please refer to **Section II** regarding provider qualifications and requirements for additional detail.

V. Additional HRSN Parameters and Acknowledgements

Nonduplication of services

No HRSN service will be covered that is found to be duplicative of a state or federally funded service, for example, housing vouchers, that the member is already receiving.

Monitoring and Evaluation

BMS acknowledges and agrees to the enhanced monitoring and evaluation requirements for HRSN services as specified in the STCs. The State will monitor and evaluate how supported housing services affect health and stability outcomes for members receiving these services.

BMS will develop a monitoring protocol and evaluation design for the demonstration according to CMS requirements and timelines. BMS acknowledges that the monitoring protocol and evaluation design must align with requirements in the demonstration STCs will be subject to CMS approval.

Attachment K
HRSN Service Matrix

West Virginia SUD Demonstration

Service Category	Service	Adult Medicaid beneficairies (ages 18+) with a SUD diagnosis
Housing/Home Environment interventions without room and board	Case management for housing	**X**
	Pre-tenancy services	**X**
	Tenancy and sustaining services	**X**
	One-time transition and moving costs *other than* rent	**X**

Attachment K
HRSN Service Matrix

	Service	Population	Social Risk Factor	Clinical Criteria for the pop
Housing/Home Environment interventions without room and board	Case management for housing	Adult Medicaid beneficiaries (ages 18+) with a SUD diagnosis	1. Homelessness/At risk of homelessness	SUD diagnosis and High service utilization
	Pre-tenancy services	Adult Medicaid beneficiaries (ages 18+) with a SUD diagnosis	1. Homelessness/At risk of homelessness	SUD diagnosis and High service utilization
	Tenancy and sustaining services	Adult Medicaid beneficiaries (ages 18+) with a SUD diagnosis	1. Homelessness/At risk of homelessness	SUD diagnosis and High service utilization
	One-time transition and moving costs *other than* rent	Adult Medicaid beneficiaries (ages 18+) with a SUD diagnosis	1. Homelessness/At risk of homelessness	SUD diagnosis and High service utilization

Clinical Risk Factor	Clinical Criteria Detail
High Service Utilization	The individual has a SUD diagnosis and high utilization of inpatient and/or outpatient services indicated by frequent Emergency Department (ED) or inpatient stays defined as more than four ED visits and/or hospitalizations in the past year, or more than one inpatient stay in the same timeframe.

Social Risk Factor	Social Criteria Detail
Homelessness/At Risk of Homelessness	The individual is experiencing one of the following conditions: 1. Homelessness (i.e., lacking a fixed, regular, and adequate nighttime residence); 2. At risk of homelessness (i.e., at risk of losing their primary nighttime residence), "Homelessness" and "at risk of homelessness" are defined in accordance with definitions specified in 24 CFR 91.5 except for the annual income requirement in 24 CFR 91.5 (1)(i).