

## Tools and Resources for Building State and Medicaid Housing Agency Partnerships

September 12, 2019

[logistics]

MELANIE BROWN, CMS: (Slides 1-4) I am a technical director at CMS and the Center for Medicaid and CHIP Services. The purpose of today's webinar: we are going to share with you some tools that are available to support state Medicaid and housing agency partnerships. We hope that after today's webinar you'll better understand how the tools can be customized to meet your state's unique needs. We also hope that you'll learn from the experience of three states you're going to hear from today that have used these tools and have implemented successful Medicaid and housing agency partnerships.

(Slide 5) We want to kick off with a brief polling question to get a better sense of who has joined us today. If you could share with us your organizational affiliation: state Medicaid housing; state housing agency; other state agency; regional or local housing organization; regional or local service provider; managed care organization; advocacy organization; contractor; vendor; or other.

Questions are coming in about when we will have the materials available to be shared. We had hoped to have the toolkit and materials posted (on) Medicaid.gov today but it looks like it will be a few more weeks. If you registered for today, you will get a notice when the materials are posted.

We'll close the poll. Looks like the majority of folks attending today's webinar reported that they were "other." If folks want to share via the chat box what some of those other organizations might be, please do so. It was followed by state Medicaid agencies--and other state agencies are also well-represented. We think the material we have today will be relevant for all of the various organizations represented. I see via the chat box some folks are indicating that they are technical assistance providers, represent professional organizations or law firms, and county government. So, looks like we have quite a varied audience today.

(Slide 6) The agenda for today:

- Welcome and background.
- Contractual partners sharing framework for IAP state and Medicaid housing agency partnership's toolkit.
- States sharing examples of successful housing partnerships: Virginia, Missouri and Oregon.
- Questions and discussion after each presentation and at the end.
- Brief closing remarks.

(Slide 7) We want to begin by providing a little background on the Medicaid IAP. [overview of IAP]

(Slide 8) The goals of the state-Medicaid housing agency partnership track included increasing state adoption of individual tenancy sustaining services to assist Medicaid beneficiaries that are receiving long-term services and supports (LTSS), and also facilitating partnerships with housing finance agencies. States that participated actually worked with a variety of different housing agencies. The most common housing partner was the housing finance agencies, but states also partnered with public housing authorities, as well. States received technical support and participated in peer-to-peer learning

opportunities so they could better identify shared goals and resources, and then begin to create and implement an action plan.

(Slide 9) This screen shows the states that have participated in the state-Medicaid housing agency partnership track over the last four years. We started working with states, I believe in late 2015. Since then we've worked with three cohorts of states for a total of 19 states that have participated thus far.

(Slide 10) Some of the key accomplishments by the states include:

- Establishing Medicaid and housing cross agency partnerships.
- Working to align existing housing and health care policies.
- Developing or expanding data matching to better target resources, examine costs and measure the impact of supportive housing.
- Developing policies and mechanisms to increase supportive housing and other community integration opportunities.

(Slide 11) I'm now going to turn it over to Melanie Starns, the director from IBM Watson Health and who leads our state Medicaid-housing agency partnership track work.

MELANIE STARNES: Thank you for joining us today. Francine Arienti, Human Services Director at the Technical Assistance Collaborative and myself will be sharing with you the framework for the toolkit today, the different elements that are contained within, and then we'll turn it over to our state speakers for them to share a little bit about how they may have used those tools to help move forward the really great work they've done in this arena.

(Slide 12) If we look at the overview of the toolkit, the toolkit is based on the IAP partnership track experience, so this is something that has been under development for a few years and has been refined based on feedback from the 19 states we mentioned earlier. It is a modular toolkit so there are several components. The first includes the introduction overview introducing the reader to the various elements contained within the toolkit. It also includes a set of lessons learned from the experience of the states in doing this type of work. The next component is a driver diagram, and we will go quickly through these elements here in a minute. The driver diagram is related to setting goals and your plans for that. The services crosswalk: we're looking at the services that are currently there. The housing assessment is an analysis of the housing-related programs and services that might exist. The action planning process, and then a glossary of terms.

(Slide 13) On the driver diagram, this is something that in some places is called goal setting and it just depends on what kind of planning structure your state or organization might use. But in our effort, we were using driver diagrams, and driver diagrams can quickly convey the goals and objectives and associated actions and interventions with something that you're trying to achieve. Each driver diagram has, at a minimum, an aim statement, which is really your quantifiable, measurable goal for success overall. What are you trying to achieve? Primary drivers are those system factors or high-level factors that are really needed in order to achieve the goal. So in some strategic planning processes these might be the key objectives. And then secondary drivers are actions or interventions that are needed to achieve the primaries which achieve the goal. So some of those may be secondary objectives or the key strategies. Secondary drivers are actions or interventions needed to achieve the primary which achieved the goal, so some of those might be secondary objectives or the key strategies.

(Slide 14) Driver diagrams, they inform action plans. The driver diagrams are not action plans. They don't have the details of what, where and when like an action plan or implementation plan would have. So we have a graphical representation of the driver diagram here for you. This is what we just kind of went through. This is a way of describing the elements that need to be in place to achieve the aim. So the aim is the clearly articulated goal, and that's the gold box there on the left. Then in the middle the primary drivers. There may be two, there may be four, depending on the nature of the goal. There may be any number of them. So that's the dark blue boxes in the middle. Those things obviously feed in, so those are the key things that are needed to achieve the goal. And then each partner driver may have a number, any number of secondary drivers. Those are those other elements that feed in and are designed to achieve the goal.

In the toolkit itself we actually have an example of a completed driver diagram that is specific to housing and Medicaid partnerships, housing-related services and supports. You can see that filled in and get a little bit better idea of how these things fit together in the topics that we're talking about.

(Slide 15) Another element of the toolkit is the housing-related services crosswalk. So the crosswalk is designed to identify what is here and now, what are currently available housing-related services and supports in your state or community. The definition of housing-related services and supports can be found in the glossary that's included with the toolkit. This really shows the relationships between services from different funding streams or through different systems.

So, if states did this, they might see that, "Oh gosh!", there is an overlap or this system serving this population and the system serving this population may offer the same service or there may be an overlap. Or gosh, when we lay it all out, we see that there's a big hole where none of our programs are providing this really important service and perhaps that's what's the goal of your effort and that becomes your primary aim for what you're working on.

(Slide 16) So this is what a crosswalk, the grid, looks like then. You can see it's this simple chart or spreadsheet. It's simple in its concept, but it takes some effort to fill out, to really gather all that information from across the different systems and funding streams. So you look at what housing-related services and support services do they currently provide. Again, this is not a what do we want to do? This is based on what is right now, so you get a good picture of what is. What funding sources—can you name them?—are paying for these services? What agency administers or oversees the funding for those services. This column is what funding mechanisms are used. For what eligible funding population is this service covered? So that lays it out and then asks if the service is offered statewide? We know some services may be geographically limited or limited in other kinds of ways. By doing that, it gives you a sense then of where are we right now and what is, and where might we have some overlap.

I'm going to turn it over to Francine Arienti with the Technical Assistance Collaborative and have her talk to you about the second half of the toolkit.

FRANCINE ARIENTI: (Slide 17) One of the key models in the toolkit that I want to cover next is the Affordable Housing Program Resource and Policy Assessment. This basically has two main components. The first is a matrix that you populate with state-specific allocations for various housing program resources that are listed in the assessment tool. Then there's also an appendix that contains program descriptions of each program along with links of where you can find that state-specific information.

Now the housing assessment really helps identify and understand the affordable housing resources that are available in your state. It's also a really great opportunity for cross-systems learning. Most likely the housing experts in your state are going to be the ones who are most equipped and knowledgeable to complete the assessment, but we really encourage states to then walk it through with others on your team so that the Medicaid and services folks can gain a better understanding of these housing resources as well. The housing assessment includes consideration for using each resource. So as you complete it you can clearly begin to see how these resources are currently being used and then where there may be opportunities to develop and expand supportive housing for your state's target populations.

(Slide 18) This is a screenshot of part of the housing assessment matrix, and while this is not an exhaustive list of the housing programs that are in the tool that you see here down the left-hand column, what you can hopefully see is how program-specific information, and considerations about how each resource can be used, is documented and then can serve as a jumping off point to explore housing expansion opportunities. So you're looking at the type of resource, how it can be used, something about the relative size of the program, considerations regarding things like eligibility requirements and allowable targeting, and then looking more closely at current policies in your state regarding these types of considerations and how resources can be used.

(Slide 19) The next component in the toolkit is the service and housing systems gap analysis. This is really designed to prompt states to consider what you've learned so far from the tools you've already completed in the kit about gaps between your current reality, where you want to be, and what you hope to achieve from your Medicaid and housing partnerships. So the gaps analysis basically presents a series of housing and services-related questions that you consider after you complete the housing assessment tool and the services crosswalk. And it asks things like: is what's currently available or being provided in terms of housing and housing-related services meeting the need among your target population? Are the best or most appropriate funding sources being used or used efficiently? Are there other resources or opportunities that can be leveraged?

(Slide 20) This series of questions is really intended to tie together what you've learned so far and then identify many of the strategies and action steps that you'll then incorporate into your state's action planning process. The state action plan template is designed to help states capture the goals, objectives and action steps needed to close the identified housing and service gaps in order to achieve your partnership goals. So for each action step, the template provides space to document who the lead staff and agency responsible for implementing each activity is and the other key partners who may be involved in implementation of each agency, start and target completion dates, and then space to document ongoing progress on the status of implementation.

The action plan template also includes a sample list of potential activities that states may want to consider for their own action plans, and these are organized by key Medicaid and housing agency partnership focus areas. This is not an exhaustive or directive list of activities, but what it really represents are those activities that many states who participate in the IAP housing partnerships' work actually incorporated into their action plans. So the activities are organized into focus areas that include things like building your partnership team, engaging key leadership and stakeholders, using data for a variety of reasons—for example, to identify your target population or examine outcomes, activities around increasing the availability of supportive housing and housing-related services, and then evaluating and sustaining your implementation efforts. That's just a sample of some of those key focus

areas for which activities are included. That said, each state's action plan will be unique in terms of its focus areas and the number of goals, objectives and action steps that are included. So the template's really a guide or a framework to get you started.

(Slide 21) Finally, the last component is a glossary of terms, and this is a list of housing-related terms, acronyms, and concepts that are commonly used that may be encountered as states seek to build partnerships between their housing and health care systems. We really encourage states to take this and make it their own, expand it to include your own state-specific programs and acronyms. Time and again we heard about the importance of creating a common language from states who were doing this housing partnership work, particularly in the early phases of partnership development where Medicaid is learning the language of housing and housing is learning the language of Medicaid, so glossaries like this can be a really useful tool in helping to establish that common language among partners.

Back to Melanie Brown for questions.

MELANIE BROWN: (Slide 22) We have time to take maybe a couple of questions about the framework before hearing from our three states who will share their experience using these tools to further partnership goals. One question is, *Are any of these tools automated or examples of a single point of entry for inputting eligibility data to determine what the client may qualify to receive?* In parentheses it says at the point of care. Melanie or Francine?

MELANIE STARNS: These are not automated for that. It sounds like what you're asking for is sort of an automated component that could be added to be part of a plan of care or of a needs assessment for individual clients, and this is not for that purpose. This is really looking at the statewide planning module. It is automated in the sense that they are computer documents or a results spreadsheet and such, but we did not build a database of services behind it. But that is something I have worked with states for. They have done that so you can as well. This would be a good front end to figure out what is there and then what you might want to build behind it but the toolkit itself is not automated as a plan of care tool or anything, no.

MELANIE BROWN: We've gotten a couple questions about particular states that have participated. I'm going to briefly go back to the map that shows the states, and Melanie and Francine, I'm going to ask you to help me with my memory recall because the cohorts start to blend a bit for me. One question was specific to Pennsylvania—whether or not Pennsylvania had previously participated because the map seemed to indicate not but someone thought that they had. I don't believe Pennsylvania has participated in any of our three cohorts. Correct?

MELANIE STARNS: You're correct. They have not, but they may have done some similar type of work within their state, just not part of IAP.

MELANIE BROWN: It's also important to note because we got a similar question about Vermont. So the fact the state hasn't participated in this particular priority area of IAP does not mean that they may not have participated in a different priority area. So the initiative that we're talking about today occurred under the community integration through the LTSS component of IAP. There are three others, one that focuses on reducing substance use disorders, one that focuses on physical and mental health integration, and one that focuses on beneficiaries with complex needs. So, if you are recalling that your state participated, it may have been in one of these other areas.

We have time for one or two more questions. *We are wondering which agencies are part of an IAP team and what the staff titles are for those who are active participants?* I'll start. Typically, the lead agency is the state Medicaid agency. The most common partner or housing partner is the Housing Finance Agency, but we did have states that were partnering, as I said earlier, with public housing authorities. Some were partnering with CoCs (Continuum of Care). But then there's also what we would call service agencies, so it may be the state's Department of Mental Health is also involved or the agency that primarily serves individuals with I/DD. So depending on the state's target population there would be other service agencies also included in that partnership team. As far as job titles I think it's so varied it would be difficult to point you to something that was consistent. Lots of policy advisors. We also had a fair share of sort of service professionals. Let me allow Melanie and Francine to weigh in.

MELANIE STARNES: I think you pretty well covered it. I think from the Medicaid agency, the Medicaid director has signed off on participation and typically then there is a lead person or division director type of person who's very much involved and then directs the folks depending on what that part of the population is.

FRANCINE ARIENTI: The only other person I'm not sure if you mentioned, oftentimes the MFP administrator was part of the team as well. Other than that, everything you guys have mentioned is right on.

MELANIE BROWN: For folks that might not be familiar, MFP refers to the Money Follows the Person demonstration program, which is also funded by CMS. We have time for one more question, here's a good one. *What is the key difference between the crosswalk and the policy assessment? They appear to capture similar information from a quick glance.*

FRANCINE ARIENTI: If I understand the question correctly, the crosswalk is capturing information on housing-related services that are available. The policy assessments, while it also has a matrix that looks similar, is really looking at affordable housing program resources and what are different policy levers for accessing those resources for a state's target population.

MELANIE BROWN: (Slides 23-24) We will have more time for questions and answers but now we'll move to our first state presentation. First Virginia, and we'll be hearing from Ann Bevan, who is the Director for the Division of Developmental Disabilities in the Virginia Department of Medical Assistance Services.

ANN BEVAN: (Slide 25) Thank you very much. It's super exciting. We're in a whole new world and I'm excited to be here. Just to give you a little bit of background on Virginia. We first sort of came together with housing and maybe it was forced a little bit, we have a settlement agreement that went into play in 2012. It focused on our I/DD population. As part of the 126 provisions that we have, there were housing outcomes that were identified. So, it encouraged us to connect with certain partners and determine how do we make access to section 8 housing vouchers better? How do we target different populations?

(Slide 26) It's also important to note that as we've moved through this and because of the great partnerships that we've had, we've been in compliance with this provision for a long time, but it really set a stage for doing much better in our state. I'm trying to move my slides so moving to the next slide: Who's Got Your Back? Our core housing partners began with our state Medicaid agency, behavioral health agency, our state housing authority, and a housing and community development agency.

Obviously some of these--of the four agencies--have larger lists and more important roles than maybe Medicaid at the time, but it was also clear that without the supporting services, housing could be at risk.

We created groups and committees to help communicate our goals. This included even developers, not just advocates and those service providers, it goes much farther than that. It's important to get as many as possible to make sure that that messaging was consistent in achieving the goal. As a result of this we had developers and providers talking to each other, preparing ahead of projects, changing how they think about individuals and their abilities to live on their own. At the same time the agencies were supporting each other and their initiatives through their Secretaries because the housing would be in one and services would be in another, as well as our Legislature.

(Slide 27) So admittedly we needed help. We began with IAP. We still have a long way to go. We started to think about how we wanted to expand some of the opportunities because we'd had such great success. So it was a great opportunity to participate in the IAP. We chose to focus on expanding our current structure and those that were on the committees and the leadership teams we had already formed. With the various initiatives throughout the state we recognized more and more that there were many populations that could be identified and we needed to determine our focus and refine our goals.

In the first phase we did things like creating the crosswalk and really defining what PSH, permanent supportive housing, is. What are we going to use as a common definition for PSH? Describing the roles of each of the teams and their memberships. We had a little bit of crossover but who's going to do what and who will take the lead? Conducting the environmental scans of PSH-related activities and completing that IAP crosswalk to better understand what existed and what we could build on.

(Slide 28) It was as inclusive as possible and it really helped funnel us into a new action plan, thinking about also new partners we could kind of add to that party. It's not just these four agencies that are involved in this and we wanted to sort of expand that. So people really began to get it. We started shifting a little bit or focusing more on existing relationships around PSH as part of the many state activities outside of what we do. And the housing team, the SJ47, recognized the importance and required annual reports that actually aligned with the action plan from phase 1 that had been developed. In November of 2018, the Governor also signed Executive Order 25, which established affordable housing priorities to address Virginia's unmet housing needs, including increasing the supply of PSH, addressing shortage of quality housing, and reducing the rate of evictions. Lastly, as part of our recent expansion of Medicaid, we're also looking to develop a supportive housing benefit. We're still in negotiations with that. But this just reemphasizes that people are actually getting this; they're understanding what we're trying to do. We're all speaking with a common voice.

(Slide 29) So once everybody gets it, we create those plans but we constantly change them. We're willing to adapt and change. So, while the first phase really helped us form that action plan and that action plan is 5,200 pages long, it really kind of refined some of the things moving into phase 2. We really maximized the use of our existing Medicaid services to fund housing transition support. Looking at what Medicaid was funding maybe as support services, how we can maximize or utilize that to support some housing initiatives. Building out the housing benefit under Compass is also something we're working. That is our waiver that we've continued to work on that I mentioned about the housing benefit.

We're trying to expand our PSH low-income housing tax credit. Securing additional PSH through affordable and special needs housing programs, and building understanding and awareness of positive outcomes associated with the independent housing. Again we have many, many more action steps and strategies that we're working on but those are some real keys that we're working on in phase 2 that came out of that phase 1. I can't thank CMS and IBM and our consultants enough for really helping move us forward. Back to Melanie.

MELANIE BROWN: (Slide 30) Thank you. Any questions for Virginia? There is a question I don't think is specific to Virginia. We'll see who would like to weigh in. The question is *Many housing agencies are going through RAD, rental assistance demonstration. Will these changes affect such a partnership?* I'm not sure I'm familiar with RAD but as you describe it seems this is a potential opportunity that could be leveraged by a partnership between a state Medicaid agency and a housing agency who are looking for opportunities to expand services to individuals requiring LTSS who have housing issues. Anyone on the panel who would like to weigh in on that question? [silence] Okay. A question for Virginia is *Did you interact much with state Medicaid waiver programs or were you primarily liaising with CMS?*

ANN BEVAN: So, I am in the state Medicaid agency and through our waiver we have a couple different waiver programs, one that's more focused on our medically fragile and one that's more solely focused on our I/DD population, went through a redesign. We worked closely with them in terms of making services that were consistent with what we were trying to do with housing. We went through a massive redesign in 2016 and added a lot of services, some of which were promoting that independent living or those housing type situations that would indirectly pay for some housing as well. That sounds weird, it's hard to explain, but it's a shared living service. I think New York also does that. But it supports those individuals in housing and then working, as I mentioned before, with that behavioral health agency. They operationalize the waivers, but they also have a housing component, working with them in terms of units. How do we target units? How do we work with the case managers in that DD waiver to target some of those units or make them available, educate, etc.? Hopefully that gets to Mr. Schmitt's question.

MELANIE BROWN: One other question for you. *Could you describe your interaction with developers? What state steps did you take to get them involved?*

ANN BEVAN: So, our partner, VHDA, Virginia Housing and Development Authority, right from the beginning they recognized that we were going to have to do a lot of education with developers in order to try and get them on board. They began bringing small groups together, large groups together, doing webinars, incorporating them into a lot of activities. Our behavioral health agency went out and met with them. The behavioral health agency also developed regional housing positions to work with individuals, advocacy agencies and the developers, and talked about how people with certain supports, whether a waiver or just case management, could help with those individuals in their development and make them successful, because a lot of them had preconceived notions. I'll tell you I was amazed at how successful it is. Now we have developers reaching out to us saying how we can help, we'd like to look at this, what can we do? It was just amazing the work that that housing authority did in bringing them on board early and all along.

MELANIE BROWN: Another question regarding the toolkit.

ANN BEVAN: The housing benefit?

MELANIE BROWN: That's a different question but if you want to address that one and the clarification about whether or not you said the housing benefit was funded by your Medicaid waiver.

ANN BEVAN: As we expanded Medicaid, closely thereafter we were working on an 1115 waiver and continued to work, as I mentioned. One of the components of that 1115 demonstration waiver is a housing support benefit that we are attempting to build out. Through the amendment and application to Medicaid it mentions pre-tenancy and tenancy sustaining services that we would like to pursue. Again it's very early on, we're still working with it, it has not been approved, but those are the types of supports that we were looking to put into that.

MELANIE BROWN: Thanks for the clarification. One final question for Melanie or Francine. *When referring to affordable housing will the toolkit apply to single-family as well as multifamily housing?*

FRANCINE ARIENTI: I think more so on the multifamily housing side because the resources that are primarily being looked at for these populations are affordable rental housing resources.

MELANIE BROWN: (Slide 31) One other question we'll save until all three states have presented. Now to Michigan with Paula Kaiser VanDam, the Director of the Bureau of Community Services of the Michigan Department of Health and Human Services (DHHS).

PAULA KAISER VANDAM: (Slide 32) Good afternoon. We were part of the second cohort of states that participated in the IAP and we had a diverse group of individuals that were really part of our overall workgroup to really move through and develop our action plan. It included folks from our Medicaid agency, as well as some behavioral health folks. It included--within our DHHS we have--a housing and homeless services area, so those folks were also involved. It involved our Michigan State Housing Development Authority, as well as our state's Homeless Association, as they were the statewide implementer of our homeless management information system. That's a homeless database that all our providers use. We are unique in Michigan in that we have a statewide system so all our continuum of care are on the same HMIS system so we're able to roll up data on a statewide basis, which made doing some of our IAP activities convenient that we could have that data and pull it on a statewide basis.

Participation in the IAP created alignment for what we should focus on, so it really helped us think about--we knew we needed more permanent supportive housing units. We didn't have enough and we wanted to make sure those we did have were going for those who needed them most. We also continued to hear that there isn't enough money to cover the case management side or supportive services side of permanent supportive housing. So we needed to pursue coverage, additional financial resources for those supportive services and wanted to do that through Medicaid, so that was on the table.

We also were very interested in bringing the statewide HMIS data into our state data warehouse and beginning to match it against our Medicaid data to understand the utilization patterns of this population, and then to think about how we might begin to deliver services a little differently based on those utilization patterns, which then led to the launching of a frequent user pilot that I'll talk about in a minute.

(Slide 33) In terms of the toolkit and resources we were given from the IAP, we used a variety of those. We were already in the process of contracting with the Corporation for Supportive Housing to do a complete Medicaid crosswalk related to our tenancy support services, so we continued on with that

contract. We are a state that carves out our behavioral health services, so the focus was really on what's currently supported in terms of tenancy supports and pre-tenancy support services today, and then what would the ideal look like. So the Corporation for Supportive Housing delivered a great crosswalk for us that talks about what we currently had, where there were opportunities, etc.

Also we had two really awesome IAP coaches and they were really helpful in keeping us focused and really developing a realistic action plan, so just props to both Kathy and Sue, who were our mentors and coaches and really helped us stay the course and think about a realistic action plan in terms of what we wanted to do. (Slide 34) Part of what I talked about, we have submitted a 1915(i) state plan amendment and we're hoping that it's supposed to take effect by October 1<sup>st</sup>. We're still waiting for final approval from CMS on that. That includes the tenancy support services that we talked about.

In terms of trying to develop more permanent supportive housing units, we worked with our state housing development authority and they are the ones who administered the low-income housing tax credit. We had a workgroup that really worked with them to update their qualified allocation plan, which is really the guiding document for how you prioritize those low-income housing tax credits to favor the building of more permanent supportive housing units and then also that those units would be specifically focused and priority would be given to those who were chronically homeless. So we were able to make some pretty significant modifications to the qualified allocation plans leading us to now additional permanent supportive housing units being developed.

While we were working on getting those tenancy support services to be covered under Medicaid, we also wanted to make sure that if we were able to get that coverage, that additional resource through Medicaid, we wanted to ensure that we were being able to provide high-quality permits for housing. So we again partnered with the Corporation for Supportive Housing to come in and do some high-quality PSH academies. We offered two of those across the state for free to permanent supportive housing providers to get everybody to a quality threshold so that once the Medicaid reimbursement took effect everybody would be able to do that.

(Slide 35) We're also partnering with CSH to conduct a Medicaid funding academy so as soon as our 1915(i) waiver is approved by CMS we'll be doing academies so we can ensure that our permanent supportive housing providers can take advantage of the Medicaid reimbursement. We're in the process of getting that scheduled since the new policy is set to take effect by October 1<sup>st</sup>.

I talked a little bit about the Medicaid data match we did. So we were able to bring in the state HMIS data and put it into our state data warehouse. We matched it against Medicaid, and it really bore out what we assumed it would, which is our homeless population is a more expensive population than our general Medicaid population. We sorted it by fee for service as well as managed care. In both instances, it still had higher costs. It had higher ED utilization. It had higher inpatient stays. We were also able to demonstrate because of having the HMIS data, which shows when people are becoming homeless and then when they're housed, we were able to run some data that showed what folks' costs were prior to housing and then once housed. We were able to demonstrate that in some key situations once housed that data did show that their utilization and costs went down and was more in line with what the average Medicaid cost was for the general population within Medicaid. So we were able to really demonstrate that this is a population that should be prioritized and we should be focusing on.

As a result of that we partnered with our state Housing Development Authority. They gave us some housing choice vouchers. We did a by name list where we found some of our most expensive homeless individuals who had high ED utilization and high overall cost to us, and we piloted a PSH intervention with them. We used some state innovation model funding that we had to launch that pilot and to pay for some of the supportive services, since our supportive services benefit hasn't come into play yet. So, we're using that money as a precursor to be able to show once housed, and we're tracking the continued ED utilization and overall cost to be able to see what a difference housing is making in terms of overall costs of ED utilization. That pilot is just finishing up its first year so we don't have any evaluation data yet, but we should be getting that soon. We are super excited about that.

In terms of some other activities we're focused on, we've been having ongoing discussions with our health plans. They're very interested in trying to figure out how they can understand who of their beneficiaries are homeless. We're in the process of talking about how we can share that information with them, what kind of information would they find helpful, so that they can utilize the resources they have within their own purview to help address that issue.

On the other hand, as many of you know, every community doesn't have enough housing for all those who need it so they're asked to develop a prioritization process. In Michigan, that prioritization process is done based on a single assessment tool that all communities are using, which is the SPDAT. And all of that right now is currently self-reported. So, you're asked a series of questions about your utilization around health care, mental health, substance use, all of these kinds of things. So, we're in the process of trying to figure out a solution where we can use real health care information to inform that prioritization process locally so that folks who have high-risk health conditions can get higher prioritization on that local prioritization list. We don't have a solution for that yet.

We're in the early discussion phases of that, but we're really excited about how do we use more realistic and real-time data to inform that local prioritization process that is just self-reporting. And our frequent user pilot has kind of demonstrated that, because we were able to compare who came off our high-cost, high-utilization list and how that matched up with the by name list that communities already had based on their local prioritization. In some cases there were overlaps with that list but in other cases there were folks who were not on that by name list. So it really demonstrated that there are some folks who would really benefit from housing, who might not score high enough on SPDAT to be prioritized in the way they should be for that housing, so we're working on a solution for how we might play that out. Obviously we're not planning to share diagnoses of any sort with the housing prioritization process or anything like that, so we're trying to figure out how to stay compliant with HIPAA, but we also need to figure out how to show that somebody has high health care risks that should impact and help them be moved up in that prioritization process. I'll stop for questions.

MELANIE BROWN: (Slide 36) There were several data-related questions that came in. The first question is *Does Michigan have a list of Medicaid data points that you're specifically collecting related to Medicaid services received by individuals in permanent supportive housing?*

PAULA KAISER VANDAM: As it relates to our frequent user pilot, we're continuing to look at ED utilization, number of ED visits. We're looking at overall costs. We know what their costs were the year previous to coming into the pilot, and then we'll be able to compare costs after they've been housed. So primarily the two points we're looking at now are ED utilization and cost as it relates to our frequent user pilot.

MELANIE BROWN: This one came up several times. *Could you say a little bit more about what data specifically were matched?* and then *What information were you looking for between the HMIS and Medicaid data system?*

PAULA KAISER VANDAM: We're a state where we use what's called a Master Person Index in our state data warehouse. We first match the HMIS data to that and in doing that we had to have a 100% match rate, the name had to be exact, all nine Social Security digits had to be exact, and the birthdate had to be exact. So when we did that match we had about a 60% match rate to the Master Person Index and from there we could match it to our Medicaid population. So when we matched it against the Medicaid population we were able to run and understand, for example, overall utilization patterns compared to the general Medicaid population, which I said was higher utilization.

And we compared that utilization both for Medicaid beneficiaries in a fee for service versus those that are in our managed care. The bulk of our Medicaid population is in managed care, but we still have some in fee for service. So we're able to dissect it by both those populations. Again in all the things that we looked at—ED utilization, costs, inpatient stays, etc., the homeless folks had higher costs, higher utilization, both in ED and inpatient stays. I should mention that for our pilot we're also looking at inpatient stays as well.

MELANIE BROWN: A couple questions are asking whether you're able to share the specific HMIS and Medicaid data match points. Some other states are interested. Is that something you're able to share, Paula?

PAULA KAISER VANDAM: Yeah. We could. We're in the process of fine-tuning a Power Point that explains all that in a document, so we would be happy to share that when it's finalized.

MELANIE BROWN: Great. There's a question about if you could say more about your process for conducting data matching between HMIS and Medicaid data. I think you addressed that, but the second part of the question is how you overcome client-level privacy concerns.

PAULA KAISER VANDAM: In terms of when we did the data match to create the by name list to use for our frequent user pilot, we worked very carefully with our statewide HMIS provider around the release of information. So when we got to the point where we identified the names and were ready to share it back with the providers that were going to participate in our frequent user pilot, we first had to share it with the local CoC by name list, their coordinated entry by name list committee, who then looked at that and based on the release of information was able to share that directly with the provider. So that's the way we worked through some of the legal consents in terms of how to share that. We're still looking. We're still in the process of doing currently a statewide HMIS optimization process and part of that is looking at this whole release of information issue and what ways we might need to improve it to do more of this kind of data sharing in the future.

MELANIE BROWN: A couple folks are asking you to clarify what SPDAT stands for and a question of whether or not you use the full SPDAT version.

PAULA KAISER VANDAM: SPDAT is Service Prioritization Decision Assistance Tool, a tool that's available to communities to use. We in partnership with our state Housing Development Authority, which does a lot of work in the homeless space in the state, jointly decided to mandate that tool as the common tool that would be used statewide to assess individuals who were housing insecure. There are two versions of it. One is called the VI-SPDAT, the Vulnerability Index, which is a shortened version. Most communities use the shortened version, the VI, to do a quick assessment. Then those that score out in

the higher range will typically get the full SPDAT after the fact. That's typically how it's administered within our communities across Michigan.

MELANIE BROWN: (Slide 37) Now to our final state presentation, Oregon. We have Kenny LaPoint, the Assistant Director for Housing Stabilization with the Oregon Housing and Community Services.

KENNY LAPOINT: (Slide 38) I'm going to talk a little bit more about how the IAP program really helped us to move on the policy levers at our state level here in Oregon. Oregon joined the IAP in that first cohort that was shown on the earlier map. Oregon Housing and Community Services (OHCS), we are our state's housing finance agency, as well as the community services agency. So not only do we operate the low-income housing tax credit program, housing trust fund, those big federal housing development programs, we also have our state's homeless services programs. So we're doing work across the spectrum. We also do home ownership and other activities as well.

We joined the IAP with the Oregon Health Authority (OHA), our state Medicaid agency, and the Oregon Department of Human Services. This really kicked off the relationship between the three agencies at the state level. OHCS had been doing a lot of groundwork with our managed care organizations, which at the time we had 16 of them across Oregon. We had done a lot of work to discuss why housing was important to the Medicaid population in the state and why there was a big need to collaborate in the work that we were doing, both on the development side and then on the services side.

When the IAP come out, our HUD field office actually contacted us and said hey, we know about the work you guys are doing on the ground with managed care. This would be a really great opportunity to partner with a Medicaid agency to further that relationship. Interestingly enough, I think at the same time that the OHA director was sending me an email, I was sending her an email saying we should join the IAP. So we were on the same page from the get-go. We formed our IAP team. As the slides show, relationships were pretty shallow prior to this point. Going through the IAP really helped us build relationships and establish the common ground for where we had opportunities to partner and where we were missing partnership opportunities currently.

(Slide 39) Following going through the IAP and developing the services crosswalk, really finding areas for alignment across our agencies, we had been doing a lot of work with the OHA to find out how we would be able to align service dollars to fund supportive services and affordable housing. We ended up moving the Statewide Supportive Housing Strategy Workgroup, which was cohosted by OHCS and the OHA. We actually hired TAC to be a consultant for that work, and TAC was also working with us on the IAP program so it was sort of a perfect match there. The folks from TAC really helped support us and big kudos to them for their patience with us as well as all the work they did to support us through the process.

The Supportive Housing Workgroup, their goal was to really advise both state agencies on what program and policy changes or considerations might need to be made to advance supportive housing in the state of Oregon. So, whether that be making recommendations on policies we should put into the qualified allocation plan to advance supportive housing through the low-income housing tax credit program or policy recommendations to the OHA on how they can expand the utilization of Medicaid resources to fund supportive services. That workgroup concluded in the fall of 2018 and final recommendations were made at that time.

(Slide 40) Those recommendations actually became a part of Oregon's statewide housing plan, which OHCS also led. There is a link here in the slideshow to that statewide housing plan. I recommend taking a look at that. But those supportive housing workgroup recommendations are a part of our statewide housing plan released in February of 2019. With our statewide housing plan, PSH is one of our six

priorities for OHCS. As we went across our state and did outreach when we were developing our statewide housing plan, we had 40-plus community meetings in our 36 counties in Oregon, and PSH was a thematic priority across the state. In every community we went to our partners and community members were saying we need to bring supportive housing to scale if we're going to address the homeless and housing crisis we're experiencing in our communities.

The statewide housing plan was launched in February of this year and was heavily supported by our governor. The governor actually released the plan. The plan also influenced our governor's housing policy agenda released in August of 2018. Although we hadn't completed the statewide housing plan yet we had a good draft going at that time and it really influenced her very large housing policy agenda.

In addition, when the OHA went out to rebid for our managed care organizations we saw what I think was a different level of collaboration and integration from their end in that they were requiring managed care organizations to identify in their requests for proposals in their rebid how they were going to utilize their localized Medicaid resources to influence the statewide housing plan's policy priorities. So, we started seeing a different level of engagement at the local level where managed care organizations, coordinated care organizations, were contacting our local housing providers and asking how they could become more of a part of the solution to the housing crisis in developing supportive housing.

(Slide 41) In addition, the statewide housing plan and the Supportive Housing Workgroup recommendations also, like I mentioned, became part of the governor's housing policy agenda, which then led to the governor's agency request budgets for both OHCS and the OHA. The governor requested over \$50 million in support resources, \$50 million in capital resources, and then over \$18 million in ongoing funding to support the residents who were going to reside in the units that we were able to develop with the \$50 million. Those supports include rental assistance as well as supportive services, so really putting together the three legs of the PSH stool.

As I mentioned in the last slide, these are the resources that were included there. In the budget request that went through the Legislature this last session--again we were really adamant that if we were going to get \$50 million development capital out on the guideline for supportive housing, we had to have the additional dollars for rental assistance and supportive services. If we did not couple those things together we knew we would not be successful in developing supportive housing in the state. Again that is ongoing funding for supportive housing. We are working on getting the initial \$20 million of that funding out the door because this was the governor's number one housing priority.

We're about to launch the state's first Supportive Housing Institute, in consultation with the Corporation for Supportive Housing as our TA provider on that. We actually just finished our solicitation process for potential project teams for four Supportive Housing Institute and I can tell you we have significant demand there for participating in that from across the state. So, we're really excited that Oregon's communities and our partners are coming together to form project teams to advance supportive housing in Oregon.

(Slide 42) Lastly, I wanted to provide you all with links to our statewide housing plan and encourage you to look at that. Our director, Margaret Salazar, recently released an op-ed with the OHA's Director Pat Allen that talks about supportive housing and the cost saving impacts as well as the life-saving impacts that supportive housing has on communities. I also encourage you to look at them. Questions?

MELANIE BROWN: (Slide 43) One question already on whether or not there were sites focusing on targeting homeless families as opposed to individuals, and if so, could you discuss the key differences in the process for targeting families versus individuals?

KENNY LAPOINT: This may be a little bit ahead of where we're at in our process right now, but like I mentioned we just finished accepting proposals to participate in our Supportive Housing Institute to get our first set of \$20 million out. As we evaluate those project proposals we know there are looks at serving a variety of different target populations. We have basically said that we're looking to target folks who are experiencing homelessness, and whether that's families, folks with severe and persistent mental illness, substance use disorder, we're expecting or likely have applications that target many different populations including homeless families. So we don't really have anything doing that right now. I know we do have partners that currently target homeless families in their developments but that has not been the result of an intentional effort from the state side. We are hoping and confident we will receive more of that in the future.

MELANIE BROWN: The next question is for all three states, but Kenny, we'll start with you. The question is asking about state versus local control and how that may play a factor in your initiatives. It reads, *Are the three states participating in the conference today, do you have local control, meaning do counties have decision-making power over the services or programs, needs and goals, or are these state-run?*

KENNY LAPOINT: If any of our technical assistance providers are on the call, they'd know the answer to this question. We call it the Oregon Way, but it's very much local control in the state of Oregon. Like I mentioned we previously had 16 managed care organizations that were local Medicaid administrators. We have seven Continuums of Care in our state of Oregon. Very much localized control. The state is playing more of a leadership role, especially as we developed our statewide housing plan, we were out in every community in the state talking with them about their priorities and what they were looking to do. We really found that the six priorities that we developed were thematic priorities that we heard across the state so we feel like locals were able to control the priorities that the state was setting. But there are a lot of local resources controlled by local communities. We like to maintain that but we do recognize that the state can play a good role in leading some of that effort.

MELANIE BROWN: What about Virginia?

ANN BEVAN: We do have a lot of local resources—and again I am not the expert – but as I understand and from our meetings there are a lot of locally managed resources. But the state did make some priorities, particularly when we entered into the settlement agreement, they established some priorities for the I/DD population, which allowed then, the local to prioritize their people. Now for the most part the locality has been very supportive, engaged. Just like we did with developers, we brought them on board very early, explained, did education, etc., and have offered up units or I'm not sure the right word that could then be used for those populations over and above what they were being asked to do. Then we have other state resources that are managed at the state level obviously from our behavioral health agency and so forth. I think we had pretty good locality involvement and continue to do that.

MELANIE BROWN: Paula for Michigan?

PAULA KAISER VANDAM: I would say Michigan is more of a state-controlled state, so all of our human service eligibility, all of that is delivered directly from the state, so our counties don't play a role in that delivery system. In terms of prioritization of the housing resources, etc., that is a local decision but by and large the majority of the way that policy and programs are run are state-operated or controlled.

MELANIE BROWN: Paula, we had questions regarding data. One was how many years of data you were able to utilize?

PAULA KAISER VANDAM: I believe, and I will have to check, we brought several years of our HMIS data into the state data warehouse, so it wasn't just a single year. I should also mention that we are currently

working on a re-occurring feed where on a monthly basis the HMIS data would be directly dumped into our state data warehouse, so we're hoping to have that in place by this fall. I'm thinking we brought in like three to five years of HMIS data when we brought it in.

MELANIE BROWN: The other question was about data use agreements. It asked if you had to do any for Michigan and if so how long did it take to get those in place?

PAULA KAISER VANDAM: Yes, we did have to do data use agreements between our statewide homeless association and our department around the use of the HMIS data. In terms of time frames, it took a couple months. We were lucky that we have a staff position that really focuses on data use agreements, so we leveraged her and her skill set to really help us navigate that and work through what concerns our compliance and security office had. We were able to really work that through with our state homeless association to be able to get the right data use agreement in place.

MELANIE BROWN: One question for Virginia we didn't get to about your pending Medicaid waiver amendment was whether or not it included security deposit coverage.

ANN BEVAN: How to answer that? Possibly. We are looking at transition services, of which a security deposit may be a part of that. Again remember we're sort of in negotiations and so forth but we are looking to see if that's an opportunity.

MELANIE BROWN: So, pending and not approved yet?

ANN BEVAN: Correct.

MELANIE BROWN: Our final question is for Oregon. *In Oregon are the rental subsidies in the state \$18 million going to be renewed annually?* I'm not sure if there's a typo there. *And is Medicaid covering tenancy supports?*

KENNY LAPOINT: So, on the rental subsidies, the \$18 million partially covers rental subsidies and partially covers tenancy services as well. Our state budget is a biannual budget and the \$18 million is projected out into the future. So yes, it is anticipated to be renewed on a biannual basis. As far as Medicaid covering tenancy support services, we expect that that will be taking place but we also believe we have a lot of work to do there. We're hoping that our Supportive Housing Institute will really help influence how we're using Medicaid in filling the gap for tenancy support services, recognizing that we do have some state general funds to do that. But when needed we want to be able to use Medicaid to pay for supportive services so we can lean less on the state general fund.

MELANIE BROWN: Another question for all presenters. *Since some of the highest utilizers of services have criminal justice involvement are any of you targeting that population?*

ANN BEVAN: We are trying to look at that. When I was talking about how we expanded our participants, we do have DOC, DJJ, Veterans Affairs and so forth that now sit on our leadership team, so trying to figure out what resources—each of those groups have different resources—and we're trying to figure out how to mesh or how maybe potential new services could help them and so forth. So they have their own resources. We know that they're high utilizers and we're trying to figure out how to partner with them and mesh them together if that helps.

MELANIE BROWN: Anyone else?

PAULA KAISER VANDAM: We are not currently. It's on our radar to begin to think about how we add criminal justice data to the data matching that we're doing, but we're not currently working on that at this point.

KENNY LAPOINT: Yes, we actually already have some supportive housing developments in our state focusing on serving folks coming out of the criminal justice system and we do have an emphasis on that population with our supportive housing initiative that we're just getting off the ground now.

MELANIE BROWN: One other question that I will try to answer: *Is this possible in non-expansion states like Tennessee?* The question came in earlier so I assume "this" is referring to the use of the toolkit and those tools, these kinds of partnerships with the state Medicaid agency and housing partners. The answer would be absolutely, we definitely work with non-expansion states, as well as expansion states. If you have further questions about that feel free to follow up. We're going to provide contact information in a bit.

(Slides 44-45) Before we close, a few key takeaways and lessons learned for all states aiming to move forward with partnerships between your state Medicaid agency and housing partners:

- It's really important to start by analyzing what is currently true. What is your current system and processes? What's actually true today?
- It's important to communicate effectively to begin creating an actionable plan.
- Always appreciate the value of data at the beginning of your process as well as throughout.
- Leverage existing resources.
- Take advantage of relevant technical support.

(Slide 46) The toolkit we hope will be available in the next several weeks. By registering for this webinar you will automatically receive notification when both the toolkit, as well as slides of today's webinar, are posted on Medicaid.gov. Here are our speakers for today with contact information. A few folks asked about receiving information about data. You can also follow up with me directly for contact information.

(Slide 47) Thank you for joining us and all three speakers. Please complete the evaluation form.

[end of recording]