

LTSS Supporting Housing Tenancy Webinar 3: Audio-Only Recording Transcript

Hannah Dorr (HD): Good afternoon everyone. I'm Hannah Dorr from NASHP. Welcome to the third webinar in the housing tenancy series. [Logistics]

Melanie Brown (M): Welcome to our third and final Supporting Housing Tenancy webinar. I want to acknowledge internal CMS members who have been working as part of this effort. Karen Llanos, the director of the Medicaid IAP Office, as well as Mike Smith, director of the Division of Community Systems Transformation, the division administering the LTSS priority area of IAP. First speaker is Melanie Starns, a consultant from Truven Health Analytics. Also Lynn Kovich with TAC, the Technical Assistance Collaborative. And Steve Eiken, also with Truven Health Analytics.

The goals for today's call:

- Follow up on the Crosswalk for state strategy development. Then questions and answers.
- Summarize some examples of state strategies, commonalities and keys to success. Then questions and answers.
- Discuss next steps.

To review the goals of the housing tenancy webinar series. During our first webinar we provided an overview and description of the housing-related services and Medicaid authorities that may cover some of these services. In our second webinar we had some great state examples of Medicaid coverage of housing-related services. Today the focus is on implementation planning based on lessons learned from states that have had some experience with these issues.

We will be making the slides and recordings available for all webinars. I believe they are available for webinars 1 and 2 on our Medicaid.gov website and today's will be available in a couple weeks.

The overall goal of this track is to assist states in understanding housing-related activities and services that can help individuals get and sustain affordable and community integrated housing. We also wanted to assist states with adoption of housing-related services within Medicaid benefits for people who need community-based LTSS. Lynn is going to talk about using the Crosswalk for state strategy development.

Lynn Kovich: I want to do a quick check-in with you on the Crosswalk. On webinar 2, Marti Knisley spent some time talking you through and having some examples of a filled-out Crosswalk to hopefully get you started, and Marti is on the webinar as well in case there are specific questions. To date, we have three questions. We got a few more submitted since we finalized the slides to the webinar.

We've gotten some Crosswalks we've received so far. You can see from the slide that again I think I've always said that the Crosswalk should begin to tell you a story of what's happening in your state. It really is meant to be a tool. It's not going to do the work. It kind of should tell you something in terms of what your gaps are and how you're funding services. So you can see from this slide that there are a variety of funding sources that have been identified by the states that have submitted their Crosswalks, and those areas include the HUD Continuum of Care and state grant funding. No surprise there. A few years ago we actually did a survey through NASMHPD, the National Association of State Mental Health Program Directors, to try to get a sense of how states were paying for housing services for people living in supportive housing, and by and large the biggest source of that funding was state grant dollars. Another

source – private donations. Money Follows the Person, both through administrative revenues as well as through MFP services themselves. For states that submitted Crosswalks the different program authorities, 1915(c), 1915(i), targeted case management and then Community First Choice. So probably no big surprises there in terms of, if the state is using Medicaid, what type of authorities are they using currently.

So again back to the story and what the Crosswalk is telling you. So for the states that submitted it, each state already identified a gap in coverage for at least one type of service and for one population as well. And for most of the states, it was really two sources of funding that were providing most of the services for people living in housing in the Crosswalk. I think we said this before. We want to do some follow up on the Crosswalk. The Crosswalk is a very important tool. It's a very important exercise for you as you begin to plan out your strategy for next steps once you have your Crosswalk and see where your gaps are in your services and/or your funding. We are hoping that we will have additional states send in their Crosswalks because what we want to do, as we have said, is group states together to the extent that we can where we see common themes among the Crosswalks that have been submitted. So, for example, states that are targeting similar populations, can we put together a 6- or 7-state call to talk specifically about what comes next?

Truven will be contacting the team lead from each of the states, that you guys identified when you filled out your Expression of Interest forms, to gauge states' interest and availability. It would be very helpful for us to have more states submit the Crosswalk and to have at least started your Crosswalk and have a good start on it to be part of these calls because it's almost: you don't know what you don't know until you start filling out the Crosswalk. And hoping that you guys aren't overwhelming yourselves with this activity. Try and keep it as simple as you can for that first draft to kind of get stuff on paper. What are you providing? Who's paying for it? What are the populations? What are the different divisions involved? It might be helpful to have each office – I know some states have had each office fill it out so that the office that works with folks with developmental disabilities will fill out one, the office that works with folks with a mental illness will fill out one, the long-term living folks. And then to kind of bring it together so that you get a picture across your state human services or however you're organized. But my caution is not to overwhelm yourself and to try and keep it as simple as you can, as you begin to fill it in. Because again, to have these calls be meaningful and to have them for folks to get something out of them, you have to have some level of information provided on the Crosswalk to make them meaningful.

With that, we want to do a couple polling questions to see if we can gauge the status of where you guys are. As I said we only have a handful of Crosswalks submitted. The questions you can see: Has your agency started working on the Crosswalk? Yes, you completed it. You're working on it. No, our state has not. Fill that out.

Second question: If you started your Crosswalk, what's been most challenging? Understanding what needs to be done after you filled it out. How to use it. Locating your Medicaid and service information. Locating your housing information. Getting your partners together to discuss it. Finding time to do the work. Looks like the main issue very clearly is folks finding the time to actually set aside to do the work. Second to getting people together, so I'm hoping that means that you've started it and you're having a hard time getting everyone together to discuss it or potentially getting people together to discuss how to approach it. Then less so on locating the information. That's good. And a little bit on how to use it and understanding what needs to be done.

Next one. Has your state agency started working on the Crosswalk? So, back to the first one. Let's see what we found. Oh good. Looks like most of you are working on it, and a good bit of you have actually finished it. A small number have not. That's it for the polling questions for the moment. Any questions? We have Marti on the line as well.

Steve Eiken: We do not have any questions in the chat box. Folks can unmute their lines and ask a question verbally.

Harry Reyes of New Jersey: I think going through the Crosswalk one of the pieces that I see is because we are still contract-based, a lot of the information is sort of caught in the contract process. So I guess I'm kind of looking at how if it were Medicaid covered how this would actually be different than the current contract process?

Lynn Kovich: It seems what your Crosswalk is telling you now is that you're funding it through state dollars.

Harry: Right.

Lynn Kovich: You're working on implementing your new state plan amendment through the rehab option so if you did it this time next year you should see that you're covering some of these services through the rehab option through Medicaid and not solely through your state funding. So you've been able to take advantage of Medicaid and federal financial participation.

Harry: Okay. That is what I was thinking and I just wanted to make sure that's the route.

Lynn Kovich: Yes.

Harry: Hi, Marti.

Marti Knisley: Hi, Harry. The only other thing I would say is that you could still look at your definitions and then compare it, obviously knowing your definition, at least on the behavioral health side I think you're in pretty good shape. But just to double check and make sure this is something we know can be covered with Medicaid. And you've been through that exercise already there about what you're going to have to cover with state funding, but you could do a double check on it.

Harry: Thank you.

Steve Eiken: Question in the chat box from Trish Farnham in North Carolina: Our challenge with the Crosswalk is that many of the functions are allowable in the current waiver case management function but were not deliberately integrated into the definition and the rate. And she asked if they will be able to get TA on how to do this. Lynn? Marti?

Marti: Yes, I would again go back to your current definition and see what might need to be changed in your contract, and so you would modify maybe what the Crosswalk would look like and say, "What do we need to modify in our provider contract? We may want to do either a time study or some kind of exercise to determine if we need a change in the rate. Who's delivering the service?" The same people delivering, are they going to be able to meet, say, Medicaid requirements for provider qualifications? So you might want to do a modified Crosswalk that enables you to get from where you are to where you would want to be to say this is going to be a coverable service. So I'm thinking contract terms, provider

qualification, and then in your case, Trish, you might also want to look at “What capacity building do I need to do?” as kind of the next box, if you will. So I think there’s a way to modify your Crosswalk to do that.

Lynn Kovich: It would be helpful, I don't know if you guys have submitted, but it would be helpful kind of going right to the question of getting TA on it, it would be helpful if you guys would submit it. Because we want to see if there are common themes across what the states are working on, so tweaking the definition, looking at the rate. Those may be good substantive areas that we could concentrate a call on.

Steve Eiken: That would definitely be one option for the small group calls that Melanie Brown mentioned we’ll do afterwards. We did have a request to repeat the question. The state asking the question noted many functions are allowable in case management but are not deliberately integrated into the service definition and the service rate. The question was whether technical assistance is available. North Carolina is one of the states that submitted the Crosswalk and I think it will be good to look at it with that in mind. If states have similar interests maybe we can get a group of states together in terms of interest in using current services versus identifying new services. The polling questions we’re asking today are intended to help us figure out how we can organize states. We’ll have a manageable number with similar challenges so we can have a productive dialogue.

Lynn Kovich: And I wouldn’t be shocked if other states are seeing this that it’s allowable. And that’s what I started talking around not really overwhelming yourself with this, but just kind of getting out on paper what you're doing. Then you could figure out what the next steps are. My gut is that other states are finding this: that what they're providing is allowable but it’s not as specifically written as it can be. I'm thinking that might be a common theme we could center a call around.

Marti: I'm thinking for anyone using the current definition and you're looking to see if you could modify that definition, you'd probably be a good candidate for that small group.

Steve Eiken: Other questions? [none]

Lynn Kovich: Next slide. Marti reviewed these questions with you after her presentation at the last webinar. But again, once you have your Crosswalk in hand these are the kinds of things you should be thinking about. Does it tell you what it needs to for you to be able to – ultimately, I think – what you guys want to do is be able to use Medicaid authority to provide housing-related supports and services to people living in permanent supportive housing. So does the Crosswalk allow you to achieve that purpose? And what do you have to do to achieve that purpose? I think even before you start the exercise, and a lot of you have started it, I hope you kind of ask these hard questions. If you're going to do this exercise, are you willing to make the kind of changes the Crosswalk will point out to you? So whatever that might be, doing a State Plan Amendment, doing a change in definition as Marti just said, looking at your provider requirements, at your regulations. So have you had those conversations with your leadership? Your Medicaid leadership, behavioral health leadership, DD leadership, with your governor’s office. So that the tool is a meaningful exercise and gets you to the place that you want to go. Understanding who that audience is, who you have to make that presentation to and making it understandable for them. Not talking in waiver speak, Medicaid speak, but really making them be able to understand what your goals are and what you need to do to accomplish that and get there, which is ultimately having people be stable in housing, which is a good thing for everyone.

And then have an idea of, what’s your timing? These things typically don't go off in the way you planned. We typically have delay after delay after delay, so you want to try and really think about that and work

that into your plan because delay is inevitable as you try to make these kind of system changes. And it's great to identify your champions and your advocates who are going to help you make your case. I also caution to manage those expectations of those stakeholders and don't let that get ahead of you or in front of you, because you don't want to have to regroup and find it's not meeting the needs of where your stakeholders have gone. So it's very important to identify who those folks are. It's also very important to manage what the expectations are as you move this exercise forward.

Polling questions three and four. Based on what you've done so far, to the extent that you can answer this question, do you or does your state plan to add a new tenancy support service, modify an existing authority to pay for the service, both, or you're not sure? Let's see what we've got. Not surprising at all. Not certain at this time. That's fair, absolutely fair. I would again encourage states that have not taken at least the first shot at the Crosswalk to submit that to us so we can figure out some additional calls around additional topics.

The final poll for this section is what Medicaid authority do you intend to use to pay for the tenancy support services in your state? 1115, the b, the c, the i, Community First Choice, targeted case management, other, or not certain? Again, not certain, but a good percentage of you do have an idea. Either 1115 or 1915(i) it looks like.

Melanie Starns: In this section we will show you strategy in states offering tenancy support services, and how they have developed services in their state and give you some tidbits. The idea being there may be ideas from a variety of different states that may work for you, you can replicate or amend and replicate, and perhaps by cobbling various strategies together it gives you a little head start. Having worked for states for 30 years, I know it was always nice to learn from someone else's challenges and avoid the potholes they may have found, because I always found plenty of potholes on my own in my own work. So practices and keys to success in other states. You see Connecticut, Louisiana, Maryland, Massachusetts and New Jersey. On the last webinar you heard in-depth from Louisiana and about the one program in Massachusetts, and they have again joined us for this webinar. We have staff from other states on the call today who will be available for questions.

There are some key reasons why these states decided to offer tenancy support services. For Louisiana, Maryland, New Jersey and Massachusetts, one of their intents was to address chronic homelessness in their state. Louisiana, Maryland, Connecticut and New Jersey also were looking to promote community integration and reduce institutionalization. So they have a little more Money Follows the Person work in the tenancy support stuff, at least initially in those states. Regardless of the reasons or why they started doing this or how they came to tenancy support services and are providing them in their state, all the states agree that partnerships is the key to this. Nobody is doing this by themselves, and obviously that's the reason for this series of webinars and this effort from CMS to encourage those partnerships between Medicaid agencies and other entities out there, particularly other service agencies and state housing agencies. But also our experienced states said local direct service providers, and then the landlords and housing developers and their associations if they exist in your state, are really important partners. They're not probably people that human services and health services typically work with but are really key to this type of service. And the advocates – housing advocates, population advocates, not just for the homeless but a whole variety of populations. I know some states are looking at a wide variety of populations that they're looking to support with tenancy services, and other states are focusing in on a single population or two. So having those advocates in play, and I know for Louisiana those advocates were really key to helping move their effort forward.

And including people who use services, Connecticut made a very clear point about this, they've been making sure we don't create for people without the people at the table. Those who are going to use the services can help inform us in a way that we don't necessarily know from sitting in our office. And then champions. I think oftentimes when we're in state government and think of champions we think of people in the Governor's office or legislators, but they can also be people from foundations or the advocates who can make the issue known, people from faith groups, etc. So people who are willing to be part of the effort and are going to sing the song from the mountaintop, bring others to the table, help the community believe in what you're doing and help you in the short- and long-term move things forward.

Those are strategies – I don't know if this is rocket science – but that again were heard over and over that were important building partnerships between Medicaid and housing agencies:

- One is to hold leadership meetings on a regular basis. We know everybody's busy, calendars are crazy, but getting that scheduled and on the calendar for long term is really a good thing to do. It may be that occasionally you don't need a meeting and you can cancel it. Nobody ever complains about downtime. But trying to wedge a meeting in at the last minute is always tough. So get in those meetings, hold those meetings, because having that regular contact and interaction really helps build the relationships.
- Establish a common understanding of systems. Its likely people in housing don't know all the ins and outs of Medicaid. Medicaid service agencies probably don't know all the ins and outs about housing. These are two very complex systems with a variety of funding mechanism and rules and regulations and different federal agencies they work with, so that's part of why CMS is really working closely with the housing agencies at the federal level to try to say we need to partner together with this. Having a common understanding of how our systems work is really key to being able to foster ideas about how we can work together.
- Setting goals that everybody can support so we know where we're going and why and generally how we're going to get there.
- Encourage open and honest communication. That includes being able to receive and give feedback, and incorporate that feedback. Don't just hear it, but hear it and say "Okay, what do we do with that? Is there a process that we can change? Is there an idea that we can incorporate that even if it came from an unusual source, we can still incorporate it?"
- Building trust takes time. Whether trust with another state agency or a housing developer or any partner you're working with, trust is the outcome of making commitments to each other, consistent follow-through, honest and open communication, and honestly valuing what your partners bring to the table. Because not everybody brings money to the table. Some people bring access. Some people bring political power. Some folks are going to bring information that can inform your discussions. So no matter who you are, what you bring to the table is important in the process.

Here are some strategies to engage housing developers, because they're probably the most unique group out there:

- We're used to working with human services and healthcare, and housing developers are generally outside of who we work with on a regular basis if we're not already doing tenancy support services. So we ask the states about that and they shared with us that in Connecticut and Maryland, for instance, they include the housing developers as part of their tenancy support team, so maybe your IAP team.
- Most states help developers understand the need for supportive housing and how tenancy support services can stabilize tenancy and reduce turnover. So it's a win-win. What's in it for them, because

ultimately housing development is a business and they want to have as few vacancies for as little time as possible, so what can you bring to the table to help make that happen? That should be of interest to them, as well as, what they can bring to that table, which is that housing, which is of interest to you and the people we're trying to serve. Start with those you have a good track record with or they have a strong interest. Don't try to crack the hardest nut first. Go where there is some interest to try to prove the concept and get some folks on board to build that momentum. And if there is no one at the table, then, like Louisiana did, they used tax credits and they created a monetary incentive that then got the interest of some developers and were able to get the ball rolling that way.

- Work to establish flexibility with developers regarding vacancy churn time. The churn time in the systems go from the time a person moves out to the time that a new tenant moves in. That's open time that landlords and developers are essentially losing money, in their eyes, so what systems can you put in place that help developers keep that money and for landlords be willing to hold that unit open while perhaps there are modifications being made for a person who is transitioning from an institution to this unit or there are other kinds of things they need to get in place. So Connecticut, Maryland and Louisiana all found ways to satisfy the need to make those modifications and do what was right for the clients, but also satisfy the landlords and developers in being able to keep those units open longer.
- Leverage your relationships with developers and the Public Housing Authorities to establish set asides, unit set-aside vouchers, whatever, specifically for Medicaid members or low-income folks. Connecticut, Maryland and Louisiana all did that. Very successful.

Okay, strategies to engage housing developers: The point we wanted to make here is that housing and Medicaid agencies can collaborate together. Medicaid can and should be at the table when looking to expand the availability of existing housing units for low-income people. At the table even when looking in the longer term about creating new supportive housing units with non-Medicaid funds using state or foundation funding. Louisiana has created and developed over 3,500 units, both developing, existing and creating new, using a mix of funding sources and leveraging support from their community advocates for their champions. The Maryland Departments of Disability, Housing, and Medicaid all partnered together to get a Weinberg Foundation capital grant to create about 40 new supportive housing units. That was a long project but those three agencies really worked with their community and with developers and now they have a stronger relationship with developers that will serve them well as they move forward. New Jersey has developed over 3,000 units using state funding. They were able to cobble it together. Connecticut and Maryland leveraged their Money Follows the Person funding to create bridge subsidies that helped, again, address that thing about churn and reducing the unit vacancy time, and that made it attractive to landlords to work with them because instead of units sitting vacant those costs would be covered while they were helping people transition from institutions. Then Maryland's Medicaid office used Money Follows the Person resources to hire housing specialists, and they provided money to their Department of Disabilities to hire staff that focused on increasing affordable housing opportunities specifically for people with disabilities. There's a variety of strategies and lots of different things you can do. I encourage you to ask questions and get in touch with these states to learn the nuances about how they did some of these things.

Steve Eiken: The next set of slides talks about developing an infrastructure for tenancy supports. We're looking at infrastructure both at the state and local level and in some cases you're going to have some intermediary levels, especially managed care organizations, but even there there's a lot of state management to make sure that the MCOs are on the same page and helping get the work done. All the states we talked to had active state roles in the processes: managing vacancy lists, authorizing tenancy

support services, and authorizing exceptions payments when necessary. There's utilization management criteria. Sometimes there are exceptions where additional funding needs to happen or exceptions to the usual process and the state needs to approve those. Connecticut, Louisiana, Massachusetts and Maryland all mentioned that. New Jersey, as Harry Reyes mentioned earlier, they're not quite into the Medicaid funding yet but they've already developed a clearinghouse specifically to manage rental subsidies and they have an Olmstead unit to expedite discharge from hospitals. There's an active state involvement in identifying the people that need supportive housing and connecting them to the services. Also Louisiana and Connecticut have special contacts for landlords and developers. So if there are special issues, including after a person is in the housing, if a landlord or housing owner has a particular concern, they have someone they can contact. Part of that I think is the assurance that there is somebody to contact. It helps the huser accept somebody in the first place. It also frankly helps troubleshoot situations when they arise. At the local level, there's the housing and service providers who are actually on the ground providing the supports people need. It says delivery and services to members and landlords. Medicaid technically doesn't deliver services to anyone except the person, but with the tenancy support services there is a lot of work with the landlords and the housing system, so we put that in there because even though the ultimate goal is serving the person, a lot of the interface is with the landlord as well.

In forthcoming slides we'll talk about how states improve their infrastructure: training to prepare people to provide tenancy supports, ongoing staff support, and expediting service startup. So the training. This was a big theme across all the states – training, training, training. Really at all levels. Direct support staff and their supervisors. Service staff in the housing system, if applicable in your state. Service staff to help coordinate the housing and services, and if there are supports provided in the housing systems, it's Medicaid-eligible where they need a service, helping them get up to speed and how to do that. Managed care organizations. Helping them understand what the service is, helping people access and authorize services when appropriate. Education on, "What do we train people on? What's the content of training?" That's the middle two bullets there. Education on the type of tenancy support services, what they are in the first place, their role in supportive housing. Training also established conceptual buy-in on the value of these services and practical tools for service delivery: "How do you really get this done?" Finally, states typically have developed and delivered the training themselves but some states have used a train-the-trainer approach for ongoing delivery. The initial lift pretty much needs to come from the state or at least have the state's blessing, this is what these experienced states have found, but on an ongoing basis there might be a train-the-trainer approach to reduce the state burden.

New Jersey is a really good example on the training front. They spent years working with providers helping them get ready for significant system and services training. Training elements are listed in the bullets on the right: the principles of supportive housing, skill-building activities, supervision, documentation, billing, and Medicaid compliance, and also contract compliance for contract funding. Really a comprehensive training approach. Ongoing staff support. Obviously the initial training we need to do to get off the ground but of course it's never really done. It may level off but it's never really done. The local staff are really the key to success and there's three tips on this slide in terms of helping that local staff do what they need to do:

1. Tenant issues can be complex and people at the local level need to be able to access information and get answers quickly. So if they need to contact the state they need to be able to get a response pretty quickly.

2. Not only, in the middle box, it's not just states being responsive to the providers but also to the housers as well, landlords and developers. If they have concerns, ideally they would go to tenancy support staff first, but if they need to get to the state, there are people they can contact.
3. Tenancy support is definitely an ongoing training. Keep skills up-to-date. Learn new methodologies. Also the opportunity for input. What's working and what's not. This is applying basic quality improvement principles and involving people in maintaining the service and helping it continue to improve to work well for people.

Finally, expediting service startup. This is a pretty significant issue. Especially when I evaluated the initial nursing home transition grants in the early 2000s, the biggest delays were delays at just finding housing. But once you've found that housing, the transition coordinators really had to hustle to get the services in place. So it was really a wait and hurry up situation, if you will. So the successful state agencies are integrally involved in the daily processes. It never ends. This is a good point to note that it's really a high-touch, high-reward type of supports and I want to emphasize the high reward at this point because the benefit of getting people into independent housing and helping them stay there, in terms of individual outcomes, in terms of cost savings for the healthcare system, the benefit is tremendous. So when I look at these slides it looks like a lot of work, and I think back to when I wore the state hat and it seems like a lot of work. But it also seems worth it, and it's a good point to mention that, because that's going to be a really significant value as we look at implementing these services.

In terms of particular steps states took to expedite the service startup process:

- Closely monitoring vacancy lists and tenant readiness frequently. Daily or weekly monitoring at the state level. Who's ready? Who has homes? Where are vacancies appearing and who's ready to go to that area? Who would choose that housing? There's still an active state-level management there.
- Identifying people early in the process to provide more time to prepare them for the move.
- Ensuring timeliness of eligibility and service authorizations. This was something Louisiana, Connecticut and Maryland all mentioned. Depending on the program authority and state rules, there can be a lot of steps to get people in service. There may need to be some adjustments or some steps to take to make the process move more quickly for people who need the tenancy supports to get people into housing.
- Vacancy payments. Connecticut and Louisiana authorize vacancy payments, which is a nice cushion in case the startup isn't as expedited as we'd like. Connecticut allowed 15 days typically but up to 60 days when there's a home modification necessary. Louisiana will pay up to 80% of the rent for two months, so about 60 days.
- A tracking system automated for efficiency, maintaining the state data, to make it easier to monitor people's progress, to find out who's available and who's moved.
- Ongoing formal meetings as well as informal communication are key. Goes back to Melanie's point about the partnerships and keeping those partnerships moving and having the structure, both formal and informal.
- A designated point of contact for developers and landlords. I mentioned this a couple of minutes ago and the four states mentioned here – Connecticut, Maryland, Louisiana, New Jersey – mentioned having a designated point of contact. It's helpful in general but also particularly helpful in terms of service startup, in terms of making sure you get access to the house, if you need to do things for the move-in like get furniture in there before the person comes, and you can do that. Making sure that everything works smoothly.

Lynn Kovich: I'm going to cover the next few slides talking about provider capacity and billing, very big issues as you move to more of a system of Medicaid. Strategies that states have used to expand their provider pool, you can see this chart that talks about the different strategies and which states have implemented those:

- One of the takeaways for this particular slide. First it says incorporate TSS into existing contracts and provide necessary training. You can see four of the states have done that. Interestingly, when I was still in New Jersey and we were kind of gearing up to do some of this, we would have conversations with the providers about the training that was coming. And many of the providers, good, good providers, thought they were providing the services we were intending in the change. Come to find out, as we began to roll out the training, which was pretty intensive, a light kind of went on and they realize, "No, no, no, this is really not the service we're providing now." This is a far different service and the training was just so helpful. So Maryland established the tenancy support services as a separate service within a Medicaid authority, so very clearly identified the service within a specific Medicaid authority. Now Connecticut and New Jersey as well trained existing housing staff, expanded the provider pool without bringing in new providers by training, again, that very intensive level of training for their existing providers. Not bringing in new providers but really concentrating on training staff. Doing that kind of skill transition in the same way we would be doing that in skill building exercises with the folks that we're working with, but kind of building those skills up with not only the folks providing the direct service but also the supervision, and understanding how to supervise someone who is providing this new kind of service. So that training is really very important on a number of levels.
- Allowing larger Medicaid providers to serve as billing agents for small direct service TSS providers. I think you'll find housing agencies, emergency shelters, really may not be equipped to have that infrastructure to do the Medicaid billing. So very important to allow that kind of flexibility within the system, because they likely know the residents best, they know the services to provide but just don't have that infrastructure to bill, so that's an important tool to have and to use.
- Reach out to your strongest providers first. I think you all know really who your go-to providers are who get the service, who understand the service, who live it and breathe it and really having them, as Melanie talked about earlier, as your champion or advocate to move the system in this way. I'm sure there are a number of providers you could point to pretty quickly to reach out to first.
- Then you really want to make sure that the service is being provided in the way that you intend, so really having good standards, good regulations so that the service that you're expecting is being provided, and there are standards to measure that against.
- As you're doing this you'll find that not all the providers are going to meet the standards or wish to participate and that can be okay. You see Louisiana only has 14 providers that provide tenancy support services across the state. You want to make sure you have a good provider pool but sometimes it might be better to have a smaller number of providers who do the service very well and can handle the numbers of folks to be served as opposed to having it so dispersed and losing control of that quality. Again, you see Massachusetts using its regional managed care companies to be those billing agents for the smaller agencies so they can provide the service but don't have to have the infrastructure for the billing. Maryland did increase its providers. They went from 20 to 24 as they combined two of their waivers and incorporated tenancy support services into those waivers. So every state is different and it just depends on your own circumstances: sometimes your own geography, your budget situation, and how you want to roll this stuff out.
- This is probably one of your more – I don't know if controversial is the right word – but definitely one of the more difficult exercises that you might go through as you begin to develop these services.

It's very, very important that the rate is right, that the providers can provide the service in the way that the state rolls it out and the state defines it in the State Plan with adequate supervision. So that rate-setting strategy is very, very important to land on a rate that is going to be appropriate for the service that the state wants to provide. So New Jersey went through a very intensive rate-setting process and then tested it, spent a lot of time on a provider survey, so providers really did a time study of the amount of time they spent in face-to-face time, in other kinds of non-face-to-face activities, to really get a sense of: "Are these the right rates? Are people spending enough time in face-to-face time?" Now Maryland incorporated its tenancy support service within an existing service at the same rate, so that is certainly an option as well. Louisiana, differently, they incorporated their tenancy support service into an existing service at an enhanced rate and they assumed less face-to-face time. I think in New Jersey we were assuming more face-to-face time, so again all different state circumstances. Louisiana also created, and Robin talked about this on the last webinar, a stand-alone service for billing for both face-to-face time and indirect through their 1915(c) waivers. That approach is not really allowed under some authority so you have to make sure you're following the rules and regs of the different authorities you're using. Massachusetts established a per diem. Their program is within an 1115 so they have flexibility to test out different kinds of payment structures. I think if you asked a provider, a provider would always say that the case rate is really the way to go but it takes some time to be able to get to that case rate. You have to have the data to support what will eventually build that case rate.

- You will find that some of your providers may not be able to have the capacity to bill for Medicaid services for many of the reasons you see on this particular slide. You have to have a certain level of staff with a certain level of knowledge. You have to have some license and some credentialed staff perhaps. You have to have adequate infrastructure, adequate technology to be able to bill and to track the Medicaid dollars. Some providers, if they're small, if they're living on a fee for service environment and they're billing as they go, if they're not providing a volume of service they may have cash flow issues and may not be able to make it in this environment. Or just developing the Medicaid billing capacity just is too cost-prohibitive for some of the smaller agencies. So in order to combat and deal with some of this, Louisiana, New Jersey, Connecticut both provide one-time and ongoing support to train providers to develop their capacity to bill Medicaid, because there's all different facets once you begin to bill Medicaid. There really needs to be an emphasis on compliance, ensuring that what you are billing you can back up with your documentation, a lot of supervision, a lot of checks and balances, and a software system that allows states to do that.

So I think there will be some limits perhaps in some of the agencies. There may be some ways to address and deal with that. You saw in a previous slide that Massachusetts allowed some of its largest providers to submit the bills on behalf of the smaller service providers, because they just will never have the infrastructure or the ability to bill. In some ways it's like a chicken and an egg because to be able to bill Medicaid you have to have some volume of service, so you have to grow, but you don't really have the dollars, the kind of capital to start up, so you're kind of spinning because you have to spend money to make money and you don't always have that money. So it's a conundrum, I think, for our smaller agencies. In the Massachusetts case allowing the larger providers to bill is a really good example of how to keep smaller providers in the network and able to provide the services that they're probably very good at providing. And some states have used a higher rate to start so you build up the rate to account and allow the provider to build up some of this infrastructure and then as the years progress, second or third year, you begin to bring that rate back in line with the other rates of other, more established kinds of providers. You might also as a state allow one-time funding, so in states still in contracts, at times when states aren't spending their entire contracts, allowing them to use some of the one-times for

some infrastructure expenditures or purchases. So there's some ways to help providers really begin to think about being able to be a Medicaid provider. As we continue to really work with Medicaid and have these services be provided through a Medicaid authority, I think this is something that states will be working on very, very closely.

Melanie Starns: I just wanted to touch base on, go back to slide 38 for a minute, and just mention that Louisiana did establish tenancy support services within the Medicaid authority, so we'll make sure that that is reflected – this may be the wrong slide – but is reflected correctly. That is something I think Louisiana is known for and I think we missed that checkmark on one of our boxes so we'll get that on the slides posted. Anything else to share about that, Robin? [no response]

One of the things we heard earlier in the first webinar were questions about outcomes and certainly lessons learned, so we wanted to share some of the outcomes the experienced states felt were really key for them, that were very useful. We asked them, "Would you use these measurements again if you had to do it over again?" and they all said yes. We wanted to share those ideas because having a good outcome measure really helps to tell the story, helps you figure out what's working, what's not. Helps you identify what changes are needed. And also can help you to leverage additional resources and supports.

For Louisiana they had two [measures] they were doing. They have probably the most complete system of tenancy supports. They looked at tenancy retention, so how long is a person remaining in their supportive housing situation and looking at the iteration of that. Then also their increase in household income. These were two that were very key for Louisiana, they would absolutely use again.

Massachusetts was focusing on homelessness and people with mental illness. They were looking at a decrease in emergency department visits. So once they had supportive housing, once that was stabilized, did that have an impact on emergency room visits?

In Connecticut they made a note to say that they really conduct a cost-benefit analysis every year so they're looking at how much it costs and what those costs would be otherwise without the supportive housing, without the tenancy support services, and they're able to use that return on investment, some of you had asked about earlier.

In New Jersey, they're looking at the decrease in the state hospital census and what are the tenancy supports, again, providing a stabilizing force in these number of lives so that they are not in and out of the institution.

Let's get into these states for lessons learned and keys to success. All the states agree that broad partnerships with entities at all levels of the process are key. Choose your partners thoughtfully and include the service recipients, include the public, include the advocates in that process. You may have a core team that's smaller and more nimble, and that is like a steering committee, and that makes some sense. But as you look at the broader team where you're trying to develop these resources in the community, make sure that you are not just staying with state agencies but that you broaden that out and have a really good set of input, and then you have a good set of people working on your behalf for you. Develop common goals that everybody can support. Gain buy-ins among the housing developers, buyers, landlords, early on in the process if that's possible. At least keep knocking on their door and keep trying to get them engaged so it's not like you have developed all this and then sort of want to lay it on their doorstep. As all of us would be, they're going to be less inclined to hug you for it than if they know it is coming and they have been part of helping to shape these ideas. And then consistent and

timely follow-through with commitments and being able to fill those vacant units when they're open does help build trust with developers and landlords.

State leadership buy-in is essential for long-term success. There is a reality in state government. You do need leadership for Medicaid and housing, Governor's office. If you have a policy advisor involved or a legislative liaison or legislators themselves, those things are helpful. Because you want this to work – these are system changes that don't often just happen within a year or so. They have an impact that is ongoing. You need to have that long-term buy-in and understanding so that the efforts can weather transitions in personnel and transitions even in administration.

Develop champions. Something we talked about earlier. Those champions can be from all sorts of places throughout the community.

Ensure your timeline is appropriate for regulatory licensing and policy changes or just the timeline in general. New Jersey can speak to the fact they got caught up in some changes in regulations and I know in some states some governors come in and put moratoriums on developing new regulations, so you have to anticipate some of that stuff in your planning.

This is a great thing: have a go-to person for each key partner agency on speed dial. We kind of laughed when this was said and folks said “No, we're serious.” Have somebody on speed dial, somebody you can talk honestly to that you can share and receive feedback from, because developing those relationships is really key to when you're trying to really wrestle with something more difficult later on.

One of the lessons is collect, analyze, and use data to show the value of your service and identify opportunities for improvement. As difficult sometimes as data is to get and analyze, it is really worth the effort. It is the way you tell your story and can kind of prove that things are working or you can see quite technically where perhaps it's not working and what needs to be changed. Be prepared for considerable provider concerns and allowing clients to manage that process. Maybe you don't have leader folks who want to jump on board right away, and it can take some time to develop your partners out there.

Louisiana suggests if you create tenancy supports, if possible, create tenancy supports as its own service with its own set of procedure codes, its own rate, its own provider qualifications. They found that is easier to do than having it woven throughout a bunch of other things. Then matching data across Medicaid and homeless management information systems can help identify and address tenancy-related barriers. And Connecticut has done a lot of work in this arena. So if you're interested in learning more about it talk to folks from Connecticut. Connecticut has worked a lot with their university to help them do that. So again another resource you may not be thinking about, but everybody has their own universities and colleges they're working with.

The common keys to success were developing strong partnerships, open and honest communication, flexibility – that's really a key. Not everything, as Lynn said, is going to go the way you planned no matter how well you've planned, and so being flexible, having not only a Plan B but maybe a Plan C and D as well. Integrative funding strategies. One thing isn't going to do it all for you if you're going to serve multiple populations. Getting that housing developers' buy-in, landlords' buy-in – really important. Provide that training, support those providers, help get them to where you need them to be and plan to do that. Expediting placement, keeping those housing units filled, really a key thing to working well with the housing industry and having them as a happy partner for you. Then really you want to be able to show your success and show the value of these tenancy support services so you can continue to gain support, political support, provider and developer support as well.

Steve Eiken: We have a few questions in the chat room. John Randazzo asks how involved HUD is in the process and if there's a go-to person in HUD for technical assistance questions, especially a question regarding waiting list preferences?

Melanie Brown: HUD is one of our federal partners, one contributing to the program support resources that are available through the IAP effort. They've also been intensively involved in the development of the curriculum that guides the program support and technical assistance we're offering, so we participate in weekly meetings with representatives from HUD to talk through whether or not this is the appropriate curriculum to make sure we're all on the same page. I think the best way for us to get questions to the appropriate HUD person, specific questions, would be to submit your questions through the technical assistance e-mail account that Truven set up and then we will route it to the appropriate HUD person. I know you said it's regarding waiting list preferences. If you could give us a little bit more information so we could figure out the best person to respond to that.

Steve Eiken: From Betsy Benito, since only one state highlighted reaching out to the strongest providers first. How did others roll out the supports to a whole set of agencies that presumably have different performance standards? I'll pitch this to our state colleagues on the line but I think the point was more around the provider agencies being stronger, not necessarily different standards.

Harry: This is Harry from New Jersey. We looked at our current supportive housing providers, which is a small group of about 50 providers who RFP'd to receive services and subsidies based on a specific initiative, individuals who have medical issues or have enhanced case management needs or have IDD/MI, serve that population or serve a forensic population. We took a survey of this group of supportive housing providers trying to find out how many direct care staff they had, so as the rehab portion of our file was approved, we then came up with a training mechanism through our school of health-related professions through Rutgers to sort of have an idea of how many individuals through these agencies, that do our supportive housing work, would need to be trained on rehabilitative practices. That came back at about 800 direct care staff members plus supervisors, and then we sort of wrapped our training around those individual agencies that are doing our supportive housing provider services, and that's the group we chose.

Steve Eiken: Other thoughts? Next question from Jake Reuter in North Dakota: Do you have examples of training curriculum available for review? We do not, but I don't know if there are states on the line willing to share their curricula.

Robin Wagner: Robin with Louisiana. We'd be happy to share our curriculum.

Steve Eiken: Is it on your PSH program website because we're actually going to be sending that out as part of our fact sheet?

Robin: I don't think it is but we could see about posting it there.

Steve Eiken: It's up to you. I thought it could save you a step.

Robin: We should probably do that.

Melanie Starns: I don't know if there's anybody from Connecticut on the line but they indicated that was something they could share as well.

Steve Eiken: We can raise that offline and share with the group somehow. Ken Edminster from North Carolina: Can the provider surveys be shared so we get an idea of how to set up one in North Carolina? Harry, I think this refers to the provider survey you all did in New Jersey, when we were talking about rate setting and the time study you did.

Harry: We can share whatever we have.

Steve Eiken: Melodie Pazolt: Is it possible to get a copy of the Massachusetts per diem case rate information? I think Emelia Dunham is the person from Massachusetts on the line. Emelia, could you respond? [no response] We'll raise that topic to Massachusetts off line. Question from Liz Buck: What do you mean in Louisiana by using it as its own service and could you describe that in more detail? I'll take a shot and then Robin can weigh in. In webinar 2 we talked about Louisiana's 1915(c) waivers, and the 1915(c) program includes multiple services. Louisiana added services, I think two, specifically for this type of support. So it was an existing Medicaid authority but a new service. Those services were specific to tenancy supports. The provider standards and rate assumptions were specific to that sort of support. Robin?

Robin: That's correct. The reason that technically it's two services is that one is tenancy supports in either a crisis or during the initial phases of tenancy. The reason we did that as a service is that for each of the services we defined within the waiver we have to attach a procedure code and we wanted to be able to authorize those services at a higher level since those are the times when people really need access to more tenancy support services. The second service definition and procedure code is once people are moved in and they are in a maintenance mode, and that is authorized at a somewhat lower level but it is its own service under the 1915(c) waivers, which is sort of the beauty of what you can do under those waivers.

Steve Eiken: Another question for you, Robin. What is the eligibility criteria to receive tenancy support services?

Robin: The eligibility criteria to participate in our Permanent Supportive Housing program is that a member of the household must have a significant long-term disability. Now once you meet that qualification and you're in the program, then how your services get paid for depends on which program within that you qualify for. Because we don't just rely on Medicaid to cover the tenancy support services. We have some individuals in the program with HIV, for instance, that are covered using Ryan White funds for their tenancy support services. So you have to meet that basic PSH threshold, and then your services funding will be mental health rehab if you qualify for mental health rehab services, if you have a serious mental illness, and the criteria for that particular program in Louisiana have to do with your score on the Locus Assessment. You'll have your tenancy supports covered under one of our HCBS waivers if you have a developmental disability or a physical disability that meets the criteria for those HCBS waivers. It's not a simple answer. There are program complexities. But that's basically how it works.

Steve Eiken: Next question to all our states from Betsy Aiello in Nevada: Do you have information on or are able to share the tenancy support services training programs or modules? Are there train to the trainer programs? I know Robin from Louisiana, you already said you can share your training curriculum, and Connecticut mentioned that as well. Do other states have curriculum/modules that are sharable?

Harry: From New Jersey. I will look into our agreement with Rutgers school to see if we can share that curriculum.

John Brennan: From Maryland. We have a case manager training manual that is available online through our website. We also have a tenant manual we give to tenants that goes over issues related to having your own unit and how to be a good tenant and those types of things. They're both available on our website, which I can send the URL to the presenter using the chat feature.

Steve Eiken: From Rebecca Melang from Minnesota: Are there national resources that can help to build provider capacity regarding billing Medicaid? I am not aware of national resources but I want to turn to the states or to CMS as well in terms of resources for getting providers up to speed on billing Medicaid.

Robin: I think a lot of times the intricacies of billing Medicaid are state-specific. Like in Louisiana we have particular claims processes on the fee for service side and our managed care organizations each have their own requirements around prior authorization and billing.

Lynn Kovich: In New Jersey – and Robin's right, a lot of this is very state-specific – but we took advantage of BHbusiness that came through the National Council. I believe it was funded by SAMHSA. It was high-level kinds of technical assistance and training, and there were three or four different modules that I won't remember today, but it was a series. I think it went through a couple of months. It was all web-based. We were able to apply, and we usually had groups of 20, 30 providers going through the training at the same time. I think we had probably three or four rounds of it that at least began to introduce the concept and have agencies begin thinking about the kinds of changes they would have to make to begin to be a Medicaid provider. Also, I don't want to keep speaking for New Jersey, but I would just offer this final thing. As agencies are beginning to apply to become a Medicaid provider, Molina, which is the entity in Medicaid, would provide training to providers to get up and running. We used to have them come to some of our provider meetings to give overviews to providers around the nuances of becoming a Medicaid provider.

Harry: Thank you so much for bringing up BHbusiness. That really was a turning point for many agencies and the three modules they used in New Jersey were changing your business module, third-party billing, and contract negotiations. There were 12-week trainings and there was one face-to-face coaching allowed through the BHbusiness contract that allowed that coach to then come in and meet with those agencies, but that really was a good part of how agencies started to look at not just Medicaid billing but how they also were going to try to survive in a fee-for-service world and just trying to understand how their business models were needing to change. In fact, we just offered it again to all of the providers one more time in the event they feel there's interest in going through these modules again.

Steve Eiken: Another question from Jake Reuter: Has any state attempted to provide tenancy supports across disability populations using a 1915(i) state plan amendment? I believe it has not been attempted yet but has any state out there submitted or is working on such an application? I'm not hearing anything. That would be pretty exciting. I would think we would have heard about that one. Last question in the chat function from Urshella Starr in California: What waiver are those services offered? This question came up when Louisiana was discussing the 1915(c) waivers. There are multiple waivers serving older adults, people with disabilities, and people with developmental disabilities. We'll have an example in the fact sheet that we will send probably early next month, early in May, a fact sheet on Louisiana. We'll have a link to the waiver on Medicaid.gov and how you can get to it. The specific example I have in mind is if you go on Medicaid.gov and where the waivers are, its Louisiana Community Choices. Robin, other examples?

Robin: Yes, it's Community Choices Waiver for the aged and disabled population in Louisiana. On the DD side, it's the New Opportunities Waiver, the Residential Options Waiver, the Supports Waiver, and I'm blanking on one of them. Of course we have also used 1915(i) authority for the mental health population.

Urshella: One quick question. So those tenancy supports, did you include those on all those waivers you just stated?

Robin: We did, all the 1915(c) waivers, not the 1915(i). It was a different approach with 1915(i).

Urshella: That's great to know because we're just doing a whole bunch of stuff with our new – that we're just sending out, our new 1115 waiver, and that would be really great to have really specific Medicaid codes for that, so thank you.

Robin: I would be happy to share the service definitions and the edits I would make to them.

Steve Eiken: We've covered all questions in the chat box. Any questions verbally? I don't hear any.

We have a couple more polling questions. First, to inform planning for future years of IAP, we may or may not have additional webinars in the series but we want thoughts on what might be helpful if we do. Question: Would you attend future webinar sessions on specific housing-related services and partnership topics? Select all topics of interest: increasing provider capacity; preparing providers for Medicaid; expanding housing partnerships; working with housing developers; training service coordinators on TSS; rate setting for TSS: measuring cost savings or return on investment; measuring outcomes; ensuring prompt start of service; data management; and data integration. I'll close the poll. Very strong interest in increasing provider capacity and in training in measuring outcomes. Lots of interest across the board but those two really stand out – preparing providers for Medicaid and expanding housing partnerships. A lot of interest across the board.

On to next steps in general. This is the last webinar in the series. In terms of additional next steps to close out the series, we're going to post fact sheets for the two states that graciously presented in March: Louisiana and Massachusetts. We've developed fact sheets so that it's handy – it's one sheet front and back. You can print it out, share it at meetings, give it to decision-makers. It's a pretty handy document and that will be coming to you in early May. We'll post it on the IAP website on Medicaid.gov. The recordings of the first two webinars – the slides and transcript – those are already available on Medicaid.gov. In May we will contact the team leads from each state, when you submitted the Expression of Interest, there was a team lead. We will contact those individuals regarding interest in small group calls specifically around completing and using a Crosswalk. So look forward to hearing from myself or one of my colleagues or the IAP LTSS e-mail from Truven Health. We will be in touch with you all in early May to schedule some time.

As Lynn mentioned before, we plan to brief states based on similar interests or needs so we may survey you as well through the email. We've got a lot of information from polling questions as well. So look forward to that. If you have questions about the information presented here, including for the HUD waiting list question mentioned earlier, please let me know. My e-mail is in the slide deck: steve.eiken@truvenhealth.com. Include the subject line "tenancy."

The two final polling questions are to inform the evaluation of IAP. They actually match questions we asked in the first webinar. We're going to ask them again and get a sense in the change in learning over

the course of the series. First: I understand what housing-related services are allowable under Medicaid. Strongly agree, agree, neither agree nor disagree, disagree or strongly disagree. We'll close the poll. General agreement, a few strong agree and neither agree nor disagree.

Next: My state has the information necessary to create a strategy to implement housing-related services in its Medicaid program. Strongly agree, agree, neither agree nor disagree, disagree or strongly disagree. We'll close the poll. We have a fair amount of neutral responses here. A fair number of agreement responses but also a fair amount of neither agree nor disagree.

Melanie Brown: Thanks to all the states participating. I think the polls reflect that most of you were able to move the needle and we were excited to see that. Thinking through next steps, I want to go back and reiterate there is an opportunity for some small-group learning sessions. We are still in the process of identifying topic areas for some of those sessions. That's why you saw some polling questions earlier asking whether or not you would attend small-group learning sessions in specific areas, so if you have some thoughts or there were content areas you didn't see reflected there that you think would be helpful, feel free to reach out to us and let us know. We're still very much in the formulation stage of that. We also thank the states who provided a case study and shared their experiences and knowledge with us. Thanks to all our contractor staff. We're excited to seem to have helped states move closer to their goals. I'm not seeing further questions in the chat box so we'll conclude.

[end of recording]