

## LTSS Supporting Housing Tenancy Webinar 2: Audio-Only Recording Transcript

Welcome to the Medicaid Innovation Accelerated Program (IAP), Supporting Housing Tenancy series, Webinar 2.

Karen Llanos (KL): This is Karen Llanos, Director of the Medicaid IAP. Our IAP team here at CMCS, Center for Medicaid and CHIP Services. I'm joined by Mike Smith, Director of the Disabled and Elderly Health Programs Group, Division of Community Systems Transformation, and Melanie Brown, Technical Director and lead of this IAP area, also with the Division of Community Systems Transformation. We have other colleagues on the line as well. Speakers on today's call:

- Marti Knisley with the Technical Assistance Collaborative.
- Robin Wagner, Deputy Assistant Secretary, Office of Aging and Adult Services, Louisiana Department of Health and Hospitals
- Erin Donohue, Assistant Vice-President, Communication and Special Projects, Massachusetts Behavioral Health Partnership
- Larry Gottlieb, Director of Homeless Services at the Eliot Community Human Services in Lexington, Massachusetts

Melanie Brown (MB): Today we're going to start with information regarding using the crosswalk for state strategy development, then questions and answers. Louisiana will be presenting a state example with Q&A. Massachusetts will also provide a state sample with Q&A, and then we'll talk about next steps. The next webinar is April 27<sup>th</sup>. Slides and recordings will be available afterwards.

These are the goals for the housing tenancy track. Goal one is understanding housing-related activities and services that will help with affordable and integrated community housing. Goal two is to increase state adoption of housing-related services within Medicaid for people who need community-based LTSS. Now to Jenna, who's going to walk us through a polling question.

Jenna Bluestein of NASHP: What funding sources pay for individual housing transition services in your state? Options: Medicaid, state general fund, HUD sources such as Continuum of Care (CoC), other, not covered or unsure. Select all that apply.

Next poll: What funding sources pay for individual housing and tenancy sustaining services in your state? Medicaid, state general funds, HUD sources such as CoC, other, not covered or unsure. Select all that apply.

Steve Eiken (SE): A little context on the polling questions. We hope you learned the answers based on the Crosswalks you may or may not have been working on. It's to show the range of funding sources currently provided and as you complete the Crosswalk you can use the information on your current funding sources to identify gaps and figure out how to use your resources more efficiently. It's to see what other states are doing and what funding sources are being used.

Marti Knisley (MK): I'm going to walk through slides on reintroducing the Crosswalk based on feedback we've gotten, then examples of hypothetical/mythical states, for those who have been working on a Crosswalk, for the purpose of looking at how to do it. If you're starting, remember the Crosswalk is a tool, one of a number of tools you will want to use in your state as you expand the services available in supportive housing and housing itself. It is not the end but rather a helpful tool along with other tools.

Defining what your goals are for using it, what you want for your outcomes are important. Once you finish it you may have new outcomes based on your first round of the Crosswalk. We're recommending you do a Crosswalk first on what exists now. Every once in a while I run into a group, particularly stakeholders, who want to use the Crosswalk of where you want to go and I think it's important. Most of you on the phone today are state staff who understand the value of taking a really good look at where services are now. You can find overlaps and gaps. It helps you identify siloes, what's coverable. You can begin that conversation with respect to Medicaid.

I will come back to this at the end but it's good to have a reminder of who your audience is. When talking about your audience, for example, for those on the phone we use a lot of acronyms and particularly when trying to fill boxes, you do that, then you share the Crosswalk for the purposes of decision-making with the decision-makers in your state and you can see acronyms across programs may not be understandable. So it is important to review the glossaries, terminology, descriptions of services. One of the benefits of the Crosswalk is you'll find that depending on what the funding source is you'll see different service descriptions, they are close but often not the same. The same with contrasting and comparing your categories, they might have different meanings, even among Medicaid recipients within your state. I remember doing a Crosswalk with a state, where a really outstanding person who understood home- and community-based services was the person who came to the meeting, she was really an expert in her area, but not in other Medicaid programs. So it's good before you begin, to review categories and at least have them in hand when you start.

I've added a suggestion, let's say you finish a Crosswalk once, then I would do a process mapping or decision analysis, because with supportive housing we're beginning before someone moves in. Then you have a point of someone moving into housing, typically, and then hopefully, permanent housing. Even with permanent housing, service needs may change. So how do those changes happen? Remembering that supportive housing is often defined as set in one place in time but in the world that you live in it's across a period of time with many different players involved, many different rules of engagement. I think Steve Eiken also termed the phrase, when we're beginning to talk about the purpose of the Crosswalk, being to discover the nuances in coverage. That's one of the goals you will have in doing this.

Also before you start it would be great for participants in the process to come prepared to talk about service rules and flexibility. We're pretty good at describing the rules but this gives us an opportunity to also describe the flexibility in programs. You'll see a couple boxes on the Crosswalk regarding financing. Again participants in the process coming prepared to discuss some of the financing rules and business rules associated with the particular program. Whatever exercise we're involved in, what are the ground rules on how to be clear with where you're going. Often we will get stuck. If you've got three weeks to finish a Crosswalk before you have to turn it in for decision-makers, remember there's always a parking lot to come back and fix areas where you might be stuck and make sure you have at least some consensus on an approach going in.

Before looking at an example Crosswalk, it's going to be displayed on a spreadsheet. It's not real and it's not a final work product. It's just to highlight questions that have come up from participants on issues they're running into with the Crosswalk. It's a hypothetical/mythical state. The state on pre-tenancy is slightly different than the state I'm going to show you on tenancy, where you can see from the poll today that many states have taken advantage of federal grants, state funding, state services and Medicaid in conjunction with affordable housing, and you piece those together, sometimes at the project level, not at the system level, together to create supportive housing for particular populations, sometimes across populations or eligibility for Medicaid, for example. We had a question earlier about

the VA, which is getting involved in a very large way today in supportive housing and factors in the Crosswalk.

In the past, and there's some real veterans on this call, you had a chance to start a supportive housing project maybe using CoC funds in a local community. I think one of the major purposes of the IAP program overall, as well as this Crosswalk, is to take a look at some more systemic approaches to going to scale with supportive housing in your state.

There is a pre-tenancy Crosswalk. I want to show some examples. A shout out to Oregon. Oregon sent in their work to date and they had color coded their various funding streams, such as blue for Medicaid. You'll see Medicaid authorities, different Medicaid methods for funding, statewide, and so forth. In this particular hypothetical state, you'll see the Dept. of Behavioral Health, which has state allocations as well as grants. You'll see a Dept. of Community Affairs, which in some states is the state agency that manages the balance of state Continuum of Care program. It's not always called a Dept. of Community Affairs but in my mythical state it is. A couple things I highlighted here. One, you see a reference to the CABHI grants that in my mythical state expire, at least the federal funds, in 2017. One of your goals may be to find out how that particular grant can be sustained as part of the work you're doing. On the green here, the Dept. of Community Affairs, these are federal grants. They come into the state, but there are also sub-state grantees that get HUD allocations, not just the state grantees. The sub-grantee may operate those programs differently, may have different strategies they employ and within those strategies, even though they're following a common nomenclature from HUD, there may be different approaches in terms of what's actually in a service contract and so forth.

Again, I'm not able to do a deep dive here, but often you will see that even when you're talking about one type of grant or a general fund allocation that there will be differences in service descriptions and differences in approaches at the local level. That would go to the question later on, not as part of the Crosswalk, but an outcome of the Crosswalk: what's the capacity building that needs to be done in your state? What is the work you need to do to get to common definitions once you have approval, for example, to change and use funds under a particular Medicaid authority? So again, the Crosswalk is in large part about the how. How are we going to go forward once we've populated the various categories?

In pre-tenancy, you may run into a category, conducting a screening and assessment, that may look different in terms of what you're screening for or what that assessment looks like by some sources. That's not shown on my chart because that would again be a somewhat deeper dive than what I'm showing you right now, but again, at the end of the day one of your goals is that common understanding, common terminology helps with the financing aspects and getting approval for Medicaid or other sources. You'll see down here I highlighted assisting with rent subsidy application and certification. There's only one Medicaid program that references assistance with this particular item and the way it's written, assisting with rent subsidy and application, if you were doing a rehab service, for example, under the rehab option, the plan service, that language for assisting with the rent subsidy may not look like that because what you're doing is, it's individualized to the person where you're assisting the person to complete a rent subsidy application and meet the requirements. That's an important point because often we run into a situation where one particular authority may be allowing you to do it this way, but when you're referencing a different authority it may be different.

Now the tenancy example. I didn't color code this one. This is a different state. I wanted to highlight a health service in particular. This state has an 1115 so they have a Healthcare for the Homeless

demonstration in one area of their state, the metropolitan area. That's made possible through a program, but it may not be sustainable so that's important that when you're again coming across the line here on providing early identification and intervention in this particular demonstration that's available. Which means that if you see here in this small box where I highlighted it, where it says see services glossary for additional information, I would also suggest to you that when you're going through the Crosswalk itself that you've pulled up the definition. You may want to have them as attachments, not necessarily part of your Crosswalk, but when you're doing the exercise, putting those up it might be a different Crosswalk where you'll just say okay, you've got this particular service providing early identification and intervention. I want to see by fund source what that definition looks like. Again you may be doing multiple Crosswalks. Crosswalk is a process, it's a tool, it's used in engineering; it's used in all different ways and in different types of work, not just in our work. We didn't invent this term but we're certainly taking advantage of it.

Again you'll see across, it adds detail and in the plan requirements eligibility by population. This is where we often see running into slightly different definitions, again by funding source or at the state level or federal level, and it's really important to understand those differences and how those have an affect going forward. Also, the eligibility requirements for certain grant programs, federal and state, the eligibility may be quite different than the eligibility for a Medicaid program. You may actually see a person being eligible for three or four different Medicaid programs but only eligible for one housing program. This is a very important distinction to make when you're going to the next step. Again, what agency, organization or provider delivers this service? You could have a very long list. You'll have some organizations who provide this service at the provider level. They may be providing multiple services: Ryan White services, maybe providing health services, behavioral health. So it may be tedious. Work that you may do outside the Crosswalk is, what's the universe of providers and what do they qualify for? What are their provider requirements? Then, what would be supportive housing requirements that would be important even under particular eligibility requirements? Robin Wagner may speak about this shortly in more detail.

So there's lots of nuances in the process of actually doing these Crosswalks. I'll mention one more. You'll see down under "Other individual housing and tenancy sustaining services", I only put two lines with arrows up here, that as you can see, specify personal care, home health, teaching and modeling activities of daily living. This list could go on for a while. Then, without going cross-eyed here, tying that to each of the authorities and what is approvable, what's coverable now, what could possibly be coverable in the future. Then you would come over to, how is it paid for and what is the criteria? Again it's important to remember that the Crosswalk itself, you may have a core group of folks working on the overall Crosswalk then you may have other Crosswalk activities or other activities or using other tools to actually get to what you want to accomplish. Completing a Crosswalk, while it might be a huge job, is not the end game. So when you're finished, ask yourself, can you achieve the purpose you set out to achieve with what you've done? What else do you have to do? What needs to be done then? How will non-coverable Medicaid services be financed and delivered? If that's not a question you're asking yourselves when you're finished, particularly when talking about some of the discrete Medicaid authorities, that's going to be very important. Certainly when you're talking about fee for service programs that are now funded and delivered and managed outside of managed care, and it may be a different question when you're talking within managed care, and as you all know, we're rapidly moving to a mostly managed system in Medicaid. So what still needs to be covered? What still needs to be done?

Are you prepared to go to the next step and what else you need to do to be prepared to do that? Coming back to the beginning, who's your audience? If your audience is your state budget director, that may be different than your stakeholder group. You may have two Crosswalks, hopefully with some internal consistency with respect to audience. What do they need and in what format? What format do you take in when you're pleading your case for additional funding versus what format when you're talking to provider groups about service definitions and service qualifications? What's your timing? How do you put in all this different information? Finally, who is your champion, or hopefully, champions, in whatever endeavor you're undertaking? That is the Cliff Notes version of work to be done on Crosswalks.

SE: One question. Betsy Bonito asked if the chart or version of the Crosswalk also asks the type of setting location where services are allowed to be delivered.

MK: That's a very good point. That's not one of our columns but that could definitely be. By the way, I think there's several more of those types of questions you can ask with respect to what's missing in a column or would be added to a column. Again I would say a specific service, who's allowed to provide it and where they're allowed to provide it and how much they're allowed to provide. We didn't have a column necessarily for the extent to which a service allows so many hours, or is utilization management going to be performed, so you could add additional columns or put those under a specific column.

SE: Right. We tried to get this to start folks thinking about what's covered and what's not and where you can find opportunities but we can go much deeper. One question I'm surprised I haven't seen yet is whether the examples Marti produced will be available. They will. It will be a couple days to make them 508 compliant but then we will make them available along with the slides.

MK: One caution. I ask folks to look at those as "how" and not "what", because these are meant to show you the nomenclature and how we populated it, but this is not a real state.

Male 1: (Name) on the phone. How can we get the version before the 31<sup>st</sup>? I think the due date is tomorrow.

SE: We're not enforcing the due date because we know you don't have all the time and information you need. You'll have more time. This is really a tool for you all.

Male 1: We just want to see Marti's version before we finalize ours.

SE: At the latest it will be available next week. We'll send it as soon as possible.

Jonathan McVey: Jonathan McVey from Pennsylvania. I was wondering how other states were approaching their interpretation of the services and whether or not they were actually included in their state plans. For example, we were going to, at least for our first stab at it, interpret the services very narrowly. So are they literally in the state plan? I was wondering if other states were using the same approach or doing something different.

SE: I know Connecticut, North Carolina and Oregon have sent Crosswalks in. Would they or anyone else like to talk about that?

MK: I would recommend you start with where you are narrowly, Jon, because it gets confusing to say does this really exist or not? There's the starting where we are and then there's the second Crosswalk,

and that is your new plan or new system. I don't know of a state right now that's not planning some kind of change in their Medicaid program. I think this particular exercise, I don't believe it is ever a one and done. It's something we would come back and use as you would expand and think about services differently.

Male 3: This is Oregon. I can try and answer from our perspective. This process has been a collaborative effort between the state Medicaid authority, housing authority and the Dept. of Human Services. The state Medicaid authority serves people with mental health challenges while DHS serves people with aging and the people with disabilities population as well as people with intellectual and developmental disabilities. I can speak more authoritatively about what the Medicaid authority, the Oregon Health Authority does. We contract all our services and supports out locally. We've tried to retain enough flexibility in these different plans, like the 'i' plan, and in some of our fee for service language so that it really depends on how creative the contractor is. A lot of these services can be legitimately provided under case management or some kind of skill building, so it really varies across the state. That's a real quick, down and dirty description of what's going on here.

SE: Thanks.

MK: Thanks for your color coding. A question just came in about services have multiple programs which could be confusing. I absolutely agree. I've seen Crosswalking used for programs as well as services. There are several different ways to do a Crosswalk. This in some respects for most people this would have been generally the way to approach it, but I would recommend when you're a service, the multiple programs, like the Oregon approach with the color coding, and as you go further into it, being able to say that's part of why you're doing this, it is you've got a service and then you've got multiple programs that might be funding it differently. Even though you may want local variation, you are going to have some common rules of the road with respect to developing a person-centered recovery plan or having a service be part of the service plan, treatment plan. That's going to be pretty much standard regardless of fund source. But you would allow some variation there. There's various different ways you can try this. There's not a single approach to Crosswalking.

SE: Thanks, Marti. Now we'll pass it on to Robin Wagner from Louisiana Dept. of Health and Hospitals to talk about how they are covering tenancy supports within their Medicaid program.

Robin Wagner (RW): In my office with me today are Michell Brown, our program manager for permanent supportive housing and who makes the program work on a day-to-day basis, and Nicole Swazey, the executive director of the Louisiana (LA) Housing Authority, our primary partner in this initiative on the housing side. They're the real experts.

I'm going to start with the definition of permanent supportive housing in Louisiana. For us, it combines deeply affordable rental housing—I might add it's deeply affordable, high-quality, community-integrated rental housing—plus voluntary flexible tenancy supports. Tenancy supports refers to those activities that help people access housing and maintain their access to housing. In Louisiana we use a housing first model. That means your tenancy is not contingent on your accepting services or criteria like you're clean, sober and compliant in seeking employment. You maintain your housing regardless of those things. Your tenancy is really based on you complying with the terms of your lease and not being evicted as it would be for anybody renting housing.

A little history of our program. This program started in the wake of the 2005 hurricanes in Louisiana. We had a lot of assistance from folks such as the Technical Assistance Collaborative, Marti Knisley among

them, the Melville Trust, a number of organizations. We were fortunate to have that assistance at this time of crisis. The crisis became an opportunity for us to start this program with the goal initially of creating 3,000 units of permanent supportive housing. Our first units were occupied in 2008. We received a special Congressional allocation of rental subsidy vouchers in 2008 and we accelerated lease-up starting around 2010. Initially we relied on disaster-related resources to get this program up and going, primarily a special allocation of low-income housing tax credits to the state of Louisiana and a special allocation of community development block grant funding from HUD for disaster recovery. However, from the beginning, despite the generosity of those resources, we recognized that the CDBG funds in particular were time-limited and that for long-term service sustainability we would have to find a way to cover services for many if not most participants in permanent supportive housing under Medicaid. What we recognized, too, is that the permanent supportive housing program would have benefits to the Medicaid program. That's our history.

I'll talk about where we are today and the scope of our current program. We started off with this program in South Louisiana because that's where the disaster recovery resources were limited to, but at this point we are statewide in our scope. We do have a cross disability program. We are serving a population with high levels of disability. As you can see, 70% of tenants have more than one disability and then 40% have three or more disabling conditions. We're serving more than 2,600 households at this point with an additional roughly 400 receiving pre-tenancy services; 2,600 who are housed. Then we are on target to house not the original 3,000 but actually over 3,500 households based on the rental subsidies we've been able to obtain so far. Nicole Swazey is certainly a big factor in our ability to get more rental subsidies to expand the program scope.

When we started from the onset we had dual policy goals. One was to prevent and reduce homelessness among people with disabilities. The second was to prevent and reduce unnecessary institutionalization of people with disabilities. The dual policy goals were reflected in the coalition that came together to advocate for this program. It was a combination of homeless advocates and advocates for people with disabilities. Of course there's a lot of overlap in those two populations given the high level of disability among people who are homeless. We also started off with the principle of separating housing and services. At least we came to that principal early. Some of the initial proposals for using the disaster resources involved having housing providers, developers, use CDBG funds to fund services and place upon them the burden of finding people with disabilities who would qualify for the program. We quickly got in there and said that that was really not a fair burden to place upon housing developers but was the kind of activity better provided by the state Medicaid agency and its partners.

Our eligibility and priorities in this program reflect those dual policy goals. Basic eligibility for our program is that you have to be a very low-income household. A member of the household has to have a substantial long-term disability of any kind. We serve people whose disability is a developmental disability, a disability related to mental illness, substance use disorder. It could be a physical disability, a disability related to chronic conditions and aging. Children with a disability can qualify the household for our permanent supportive housing program. Within that broad eligibility, we do give priority, preference points if you will, for permanent supportive housing units, to individuals transitioning from institutions such as nursing homes, ICF/IID. We also include jails and prisons as part of our institutional definition. We also give priority points for PSH units to households that are homeless.

The program is a partnership between two state agencies. We're kind of fortunate in that the Louisiana Dept. of Health and Hospitals, in addition to being the single state agency for Medicaid, also includes the operating agencies for developmental disabilities, aging and adult-onset disability, behavioral health,

and public health. That means that many of us who operate programs for these groups under Medicaid and under other funding sources are all under one roof, which has really helped I think with the collaboration. We're also fortunate to have a state-level housing authority to work with that is co-housed, coexists with the Louisiana Housing Corporation. The housing authority was actually created for the specific purpose of administering the vouchers for our permanent supportive housing program, but there's a real beauty in having the voucher administrator co-housed with the corporation that provides the Low-Income Housing Tax Credits that are significant to our housing strategy.

Our housing strategy for many of our units combines the Low-Income Housing Tax Credit program with rental subsidies. The Low-Income Housing Tax Credit program can be used to produce units that are subsidized down to a certain level of area median income. So we use the Low-Income Housing Tax Credit program to get our units down to 30 and 20 percent of area median income. That of course is not affordable for folks who have zero income, so we do have the additional layer of rental subsidy that makes all our units available to our households at 30% of their income. All states have a Low-Income Housing Tax Credit program. The way we incentivize the creation of permanent supportive housing units is in the qualified allocation plan for the Low-Income Housing Tax Credit program. We give points to developers or housers who agree to set aside 10, 15 and in some instances up to 20% I believe of their units for permanent supportive housing. We generally don't go above that because we want to keep this community integrated, but in some instances we do have some units at higher concentrations.

You can see in this slide the rental subsidies we layer on top of the units that are subsidized through the Low-Income Housing Tax Credit program. The result is that the vast majority of our units are in new and redeveloped properties that are extremely high-quality, mixed income, and include market rate units. That means the people with disabilities we serve are housed next to people who are professionals, who come from all kinds of walks of life and all kinds of income levels. Again these are very high-quality units with many amenities. In addition to the units created through the qualified allocation plan and 10-20% set asides, we do have 230 Shelter Plus Care rental subsidies set aside for our nonprofits that focus on serving the homeless. In those few projects as many as 50% of the units may be permanent supportive housing. The pictures in this slide are of some of our actual participating properties. So that's the housing strategies.

I'll talk about the service strategy. Let me talk about what tenancy supports consists of in three stages. Like Marti said, you have to begin this work before a person actually moves into a unit. Pre-tenancy involves:

- Engaging the person and, sometimes, finding the person if it's someone who's homeless.
- Helping them address eligibility requirements and barriers.
- Helping them make application to individual housing opportunities.
- Helping them clear credit histories that may be a barrier to their getting housing.
- Seeking reasonable accommodation for people who have felony convictions or who have debt that needs to be addressed and is related in some form or fashion to their disability.
- Taking them to actually see the units they might rent.
- Helping them make a decision on whether the housing opportunity is the right one for them.

If it works, there's also very intensive work in helping them arrange for the actual move, making sure they have all the essentials. Timing in terms of making sure all the paperwork is in and the basic amenities are available in the housing before the person actually makes the transition into the unit, makes the transition from an institution into the unit. Then also helping them with the initial adjustment

to their new home and neighborhood. In the initial phases of move-in, you'd be helping them also to know transportation routes and how to get to services from where they live. Help them understand the terms of their lease and how to get along with their neighbors.

Ongoing tenancy consists of:

- Furthering individual goals.
- Helping them achieve those goals.
- Addressing any crises that may arise around their housing.
- Eviction prevention.

In Louisiana we are funding these kinds of services, tenancy supports, under Medicaid through our 1915i for behavioral health and under several 1915c waivers. We have other funding sources as well. Our strategy when it comes to funding services under Medicaid has been to incorporate the service into all of our HCBS programs for people with serious mental illness, developmental disability or physical disability under our HCBS waivers.

In this slide, it's how we're funding the tenancy supports. The 1915i is very important to funding tenancy support services. Our 1915c waivers for the age-disabled also come into play as do our ID/DD waivers. We fund services for some folks in tenancy through Ryan White funding. We use CABHI for folks who have substance use disorder; for chronically homeless households with a member with a substance use disorder. It helps in the short run but there are time limits on CABHI so we have to look at more permanent sources of funding for these individuals. We have a few individuals funded through VA. The CDBG, which is also significant in funding services at this point, is the initial services funding we got as part of the disaster recovery effort. Many folks in CDBG we believe will potentially qualify for Medicaid funding of services perhaps through Medicaid expansion, which will happen in Louisiana starting in July of this year, perhaps as we look at them more closely for eligibility for 1915c waivers or mental health rehab type services for those who have SMI.

I also have a line here where when we ran this data I couldn't identify funding. That's because when we were doing this analysis in December/January we were in the process of transitioning behavioral health services into our five managed care plans, so there were issues in files coming over. Most of those will probably fall into the 1915i line of funding.

One thing I failed to mention is that tenancy supports done correctly almost always involve some time that is not face to face, if it's only tracking the person down in an effort to engage them around services. But non-face to face time can also come into play if the provider has to work with a landlord around eviction prevention. Sometimes the landlord is no longer willing to talk to the service recipient and will only deal with the provider in terms of negotiation or eviction prevention. This work is very intensive and inevitably involves some time that is not direct skills building or counseling with the individual. I'm going to present you two different ways of dealing with tenancy supports. Under the 1915c waivers, tenancy support has its own service. It has its own service definitions, its own service code. It is not part of some other service. It is not part of waiver case management. We recognize that you can incorporate these services into what case managers do but our reality here is that our case managers probably wouldn't take this job on or do a very good job of it considering everything else they are involved in doing for 1915c waiver participants, so it's very helpful that under 1915c waivers you can define tenancy supports as a service and in Louisiana we have. I think at this point we may be the only state that is providing tenancy supports as a discrete 1915c waiver service.

Under our 1915i for mental health, we've done it a little bit differently. I'm not going to get into whether we could have done it otherwise under 1915i, but the way we have done it in this particular benefit is made it part of CPST and PSR services to people with serious mental illness. In recognition of the fact that there is non-collateral time, non-face to face time, involved in delivering the services, we pay at a higher rate when our provider is working with somebody who's in the permanent supportive housing program. Again in Louisiana's 1915i you can only bill CPST and psychosocial rehab, PSR, for your face to face time. But if you're working with a permanent supportive housing client, then you can use a modifier that is a signal to pay that service at a higher rate.

Now about the providers. We know that this requires quite a bit of dedicated effort on the part of permanent supportive housing providers. So we have a lot of requirements for placement that providers have to meet in order to provide the PSH service, bill that particular code under the 1915c waivers, and bill the modifier under 1915i services:

- They have to first of all be an accredited mental health rehab provider.
- They have to contract with all of five of our managed care plans.
- They have to enroll in all the 1915c waivers under which tenancy supports is a service, because our 1915c waivers are not in managed care. They are outside managed care and in fee for service.
- Our PSH providers also have to go through training and certification with Michell and her staff and contractors on how to deliver tenancy supports.

This has tended to right size our provider pool. It's not as though all few hundred waiver providers or mental health rehab providers are also doing permanent supportive housing tenancy supports. I think it would be problematic if they were. If that were the case, they might have a couple of PSH tenants in their caseload but they wouldn't have the kind of critical mass that would make it worth their while to put in the extra effort that it takes to assist people in pre-tenancy and maintaining their tenancy. So at this point we have 14 providers. If we need additional providers Michell works with our managed care organizations and other community contacts and does recruiting when necessary, and providers can knock on our door and express an interest, but we do make sure that they are fully informed of all of the steps they have to take in order to be a PSH provider. What's implicit in all this is if you are a permanent supportive housing provider in our program, you have to serve all types of disability. You cannot limit yourself to SMI or DD or substance use disorder. You have to work across the board with all forms of disability.

As a result of that, we have a mix of PSH provider agencies. They come from agencies that have worked with rapid rehousing in illness continuum, agencies that have provided waiver services typically, and agencies that have focused primarily on providing mental health services. Those various kinds of agencies have come to the table and gotten the additional qualifications and enrollment necessary to serve across disability populations.

Here are the results of our program thus far. Remember those dual policy goals we had around serving homeless households and households with disabilities. A little less than half the households currently housed were homeless and of those half were chronically homeless. Ten percent of households we have housed were institutionalized previously. Additional information, of those we're serving 40% of the household members had a substance use disorder. We have the results. We have a 96% retention rate. What we mean by that is the household has not had a negative outcome. We have had some folks move on from the program. Also because we serve older adults with disabilities we've had tenants who died

and tenants who moved out of state. The numbers we include in that 4% with negative outcome are people who were terminated from the program, people who went to prison or had other negative outcomes. So we really had excellent retention rates with a very challenging-to-serve population.

As our PSH providers get people stably housed, they can then begin to work with them on issues like improving their income. A lot of times that takes the form of assisting them in pursuing their Social Security disability applications and 61% of our households in New Orleans, which is the major part of our program, have seen an increased income since becoming housed in the program. The final bullet point is a little bit dated, we need to update the numbers, but in around 2010-11 or so we ran this and saw 20% reduction in Medicaid acute care costs. We are in the process of updating that analysis but the goal, what we hope to see is that we continue to see a reduction in acute care and emergency room type costs, and an increase use in preventative services.

This slide is just to show you the amount of Medicaid penetration we have in our PSH program despite not yet being a Medicaid expansion state. Part of the reason we have such high numbers of people housed in pre-tenancy who already have Medicaid is because Louisiana is a state that will make the disability determination prior to the Social Security Administration making that determination, using the same criteria but making that determination to establish people's Medicaid eligibility. So we're often able to get them covered under Medicaid before the Social Security disability determination is made.

Lessons learned: First of all, it was really important to get the buy-in from housing developers and providers. There was a lot of resistance to including points in our qualified allocation plan. The PSH set asides, we now have housing developers and property managers who are huge fans of the program and who promote it among their colleagues. I think the reason we were successful is we did not ask them to provide services. We made sure we get the tenants in line for them quickly. We are willing to lose the housing if we can't get somebody housed quickly enough. We have time frames we have to work within. If we don't get people into a unit within a given time frame, that property provider is able to rent to someone else. They will give us the next available appropriate unit that comes up but we're not holding up their ability to draw down rents. That speaks to why it's so important to have effective pre-tenancy services in there and intense work in the pre-tenancy phase, because landlords do not want to hold units vacant for long periods of time.

We also played around with centralized versus decentralized functions. We had waiting list management for various PSH projects in different areas managed at the local level. We've gone to centralized management of applications and waiting lists, and that actually has worked out better in terms of getting consistency in those functions. We've also experimented in contracting out some of the basic program activities like taking applications for PSH and looking at whether people met the basic eligibility criteria. That was contracted out for a period of time but didn't work very effectively, so at this point that task is managed by Michell Brown and her staff.

Let me talk about what state staff do versus what our Medicaid enrolled and contracted providers do. Michell's staff takes the applications for PSH. That's an application that looks at what services you're receiving that establish you have a disability, but it also looks at what are your qualifications according to HUD criteria for the housing units and housing subsidies we have in this program. Michell's staff provides appealable notice if people meet program requirements or not. Michell's staff look at placing people on the appropriate waiting lists for the housing units in the areas and of the type they're interested in and qualify for. Michell has staff called tenant services liaisons that are available to landlords should issues arise that are not being successfully handled by the provider or the individual

tenant. Services liaisons can also step in to provide services if people lose their Medicaid eligibility temporarily for reasons such as not following up on their applications and so forth, so they're a very important adjunct to the services providers. So it is very helpful to have staff at the state level that can perform these kinds of functions. I should add, it is helpful to have a pool of money, whether the state general fund or CDBG dollars, to assist individuals who maybe temporarily are not covered under Medicaid.

A little bit on why the program has worked. I think we had that joint advocacy on the part of homeless and disability advocates both at the state and federal levels advocating for the vouchers. I don't think we would have had the success if not for the very great power of that advocacy. It's been extremely helpful to have Nicole and Louisiana Housing Authority to administer a critical mass of vouchers for this program. We've got 61 or 64 Public Housing Authorities at least. Without a critical mass located at the state level, there is a certain amount of effort involved in going around to Public Housing Authorities selling them on this program and getting the commitment of rental subsidy vouchers. So we were very fortunate that not only do we have a critical mass of vouchers administered by Nicole's shop but we also have Nicole's leadership in approaching the PHAs and getting additional commitments to this program. It is such a great working partnership. An example is when developers apply for those Low-Income Housing Tax Credits and they check off the box saying they agree to set aside units for our program, Nicole comes over to the Dept. of Health and Hospitals here and sits down with us and says "I've got a developer offering this number of units, this number of bedrooms in the unit, this location." At the Dept. of Health and Hospitals, with all those operating agencies, we get to sit around and say whether we think the units are located in a place that has transportation and is where somebody in our programs will want to live, whether the unit configuration is correct for the kind of households we have to serve, all those kind of things, to say yea or nay to whether these housing developers will get the tax credits or not. That's the kind of collaboration we're able to have at the state level.

It's been very important to be able to combine the tax credit program with a rental subsidy. I talked already about the separation of housing and services. I'm not going to belabor that. Then I mentioned how important it is to have some states that can be a contact for the landlord, the property managers, the housing providers that can get there in a crisis situation and can resolve problems. Questions?

SE: We have 20 questions in queue and 10 minutes until we learn about Massachusetts. One asked what work was being done between the startup in 2005 and the first placement in 2008?

RW: The work being done was actually rebuilding housing in New Orleans.

Nicole Swazey (NS): I would also add with another allocation of disaster CDBG dollars we created what we called a transitional assistance program that took people and gave them rental assistance for two years with those dollars, and we had actual contracts with the owners that they would agree after the two years of this transitional assistance they would commit and take our vouchers, because we were just so adamant, everybody was, that we were going to end up with a long-term subsidy. So we ended up assisting 400 some odd people with that program and all those people transitioned onto our permanent voucher subsidy. Creating a housing authority was no small feat as well so that was a lot of the work that took place, too.

RW: But it is important to note that literally we were having to rebuild and rehab housing in south Louisiana. There was a huge housing crisis in general.

SE: The next questions are around the tax credit. What incentives are provided to developers in the LIHTC set aside and how are the rents subsidized?

NS: Initially any developer coming in for what was called our Gulf Opportunity Zone tax credits, they had to set aside 5% of their units for people in need of permanent supportive housing at 20% rent, because we didn't know that we were actually going to get the vouchers. Once we received the vouchers we were able to take their rents up to the Housing Authority payment standard, which is 110% of the fair market rent. When those GO Zone tax credits went away our QHC developers could set aside 5-10% of their units for people in need of PSH and they still have to make that initial commitment at the 20% rent as we are getting to the end of our voucher allocation. So once we allocate all our vouchers we have a commitment to continue in our qualified allocation plan for the set aside of PSH units, which means as long as there's Medicaid funding to provide the services that we can keep creating a pipeline of PSH units.

RW: And we will have households that can qualify and handle the rents at the 20% of area median and particularly as they're assisted to get their Social Security disability benefits.

SE: What strategies do you use to make sure the developments remain viable for 15-plus years if they set aside so many units? It sounds like one factor is there's a 5% unit set aside.

NS: The vouchers we have, we can do a 15-year housing assistance payment contract with a 15-year extension that layers over top of their 30-year use agreement with the tax credits.

SE: There are questions about the vouchers and rental subsidies. How did Louisiana target the section 8 vouchers to the program?

NS: That's where we got lucky with our special allocation of \$20 million for 2,000 project-based vouchers and \$50 million for 1,000 Shelter Plus Care subsidies, both of which are being renewed annually now, so that will continue to be a resource for us. We are truly a very unique housing authority in that we only have project-based vouchers. No other housing authority in the country has that. However, every housing authority that has a Housing Choice Voucher allocation has the ability to project base up to 20% of those vouchers. In fact, there's some new legislation I've seen that's actually going to let housing authorities project base more. So more to come on that.

SE: There was a separate question about whether the vouchers were tenant or project based. The vouchers are project based, right?

NS: Right. Under the Housing Choice Voucher program they are project based and interesting to anybody familiar with Shelter Plus Care, which has now become CoC Rental Assistance under the new HEARTH Act allowed for tenant based, project based, and sponsor based. We actually started off with all three components. Seven years later everyone is tenant based under that Shelter Plus Care allocation, which gives some nice flexibility. Part of the reason our turnover rate is so low is because we house people no matter what it takes and the amount of time spent rehousing people can be greater than initially housing people.

SE: Are there any local PHAs participating in the program with their section 8 vouchers?

NS: We have commitments from three local PHAs that were part of our Section 811 Project Rental Assistance demonstration program. We're in the process now of working on MOUs with those three

PHAs and how we're going to move that forward. Also the Housing Authority of New Orleans has awarded project based vouchers to developers that have PSH commitments as well. They've been a long-time partner back to 2008.

SE: How long are landlords asked to hold a unit?

NS: We have a PSH set aside agreement we can share with everyone. At initial lease-up we ask them maybe it's 30 days, maybe 60, the numbers are escaping me, and then no longer than 30 at turnover. With the project based vouchers we pay up to two months vacancy payment at turnover, which is 80% of the contract rent. The 811 program actually lets you pay 60 days upfront so at initial lease-up if it takes you that long to fill a unit you can at least pay that owner 80% of the contract rent.

RW: Sixty days may seem like a lot but anybody who's worked with nursing facility transitions and other complex transitions knows things come up and you may think you have a move-in date and delays happen. It's still incumbent upon the provider working effectively with the person to get them in the unit.

SE: Is there a time limit to how long a person can remain in PSH?

NS: No.

SE: How are developers getting rents down to the 20%? I think we answered this in terms of the 5% of units and the 15-year agreements you have with them.

RW: Essentially it's the Low-Income Housing Tax Credit they get that helps them underwrite.

NS: They have layered financing.

SE: How are you able to use year-to-year renewals to support tax credit projects? Are investors concerned about the volatile nature of the annual renewal?

NS: Investors are always concerned about where the funding is coming from and all HUD funding is always subject to appropriations but you're talking about HUD Housing Choice Voucher program and their homeless program that so far those programs have been pretty safe bets. That's what I tell investors all the time. I'm giving you on the Housing Choice Voucher side a 15-year contract with a 15-year extension that gives an out clause should there not be funding available. The same on the 811 side and the same with CoC rental assistance. It's an education piece for investors. We have investors we work with all the time now. We have investors that were fine once and now have become skeptical but you just keep having the same conversation with them.

SE: There's a bundle of service questions but we'd like to hear from Massachusetts as well. An example of the waivers and the 1915i state plan amendment: those are available on [Medicaid.gov](https://www.Medicaid.gov) and we'll send links to folks on the line. Melanie Starns put together a fact sheet on programs we want to vet with the state and send you. That will answer some service questions as well. I'd like to thank Robin, Michell and Nicole for their time and pass it on to Erin Donohue from Massachusetts Behavioral Health Partnership.

Erin Donohue (E): Hi everybody. I'm AVP for communications and special projects here at MBHP, Massachusetts Behavioral Health Partnership. We are the behavioral health contractor for the state for the MassHealth PCC plan, the primary care clinician plan. So we manage behavioral health for usually

around 400,000 people we are covering at any given time. We've held this contract with the Commonwealth since 1996. The folks we serve obviously are very medically complex, very vulnerable individuals. I'm going to talk a little about CSPECH, the Community Support Program for People Experiencing Chronic Homelessness. Its history, how it works and its results. I'll tag team this with Larry Gottlieb, one of our great providers here in Massachusetts.

Brief history overview: It was created in 2005 so over 10 years ago and basically through an advocacy partnership with the Massachusetts Housing and Shelter Alliance, also known as MHSA. That's how I'll refer to it. So MHSA and MBHP got together and said we want to find a way to improve care and reduce costs for chronically homeless individuals on Medicaid. So a performance incentive was written into our contract with MassHealth as CSPECH. How CSPECH relates to CSP, it's basically a division of our Community Support Program. So it's community-based care coordination and tenancy support services.

Who's eligible: You have to be chronically homeless and we use the federal definition of chronic homelessness, which you see on your screen. This definition was just changed slightly, went into effect in January. But basically it's someone with a disabling condition who has been homeless continuously for a year or more or who has had four episodes of homelessness in the past three years. That's been tweaked slightly but that's the general population we're talking about. They have to have a mental illness and/or substance use disorder or be at increased medical risk. Again these are very vulnerable individuals.

A little bit about Housing First, which Robin touched on. I thought she gave a great explanation. To add to that, Housing First is not about being a good client. It's about being good tenants. So very much you separate the housing from the services. But it also really flips the traditional continuum of care of homeless services on its head. It says if you've got someone with mental illness with addiction with medical complications, they're not going to be able to jump through the hoops of street outreach and detox and shelter and transitional housing. It's very difficult to ask someone to get their life back together when they don't have a stable place to lay their head at night. So Housing First is really about putting the housing at the front end and wrapping the services around that person. So CSPECH is a companion to the Housing First model.

CSPECH was developed by MBHP and the exciting news is that with social innovation financing here in Massachusetts, which is essentially where private investors front money for social intervention, and then if specific goals are met those private investors get paid back with public dollars. With social innovation financing in Massachusetts we've been able to actually expand CSPECH not only for those on MBHP but those at the other managed care entities and Massachusetts, and there's about five of them. Now if you are in managed care on Medicaid in Massachusetts you have access to this service. That's really very exciting for us.

The premise behind this is when someone is in PSH they have that stability, they have that support and they're better able to link up to resources and services. A little bit on the Community Support Program. That is one of our levels of care and again CSPECH is a subset of that. CSP is not clinical service. It is really about assisting members, improving their daily living skills, helping them link up with benefits, housing, medical care, behavioral health care, transportation, recovery, peer services. It's not so much about the clinical intervention as it is about getting the person to the clinical intervention. The other part of CSPECH is that the strategic partnerships have been key. We contract with eight providers in our network and they bill us for the CSPECH service and those partners also work with housing providers who have the available vouchers and state and federal funding for housing. It's a great way for providers

to be able to leverage. They might have money for housing and not have money for services. That's where CSP comes in. In the past year we had about 600 people participating in CSPECH.

CSPECH came about through the 1115 waiver, again written in as a performance incentive in 2005. Originally CSP, so the parent level of care if you will, is billed in 15-minute units so one unit equals 15 minutes. What we realized is that didn't make a whole lot of sense for CSPECH because it really is more of a longer term service. You can actually get an initial offer assignment for CSPECH is 120 days. It's about an ongoing relationship with a case manager. We changed it to have one unit equal one day so that's how they bill, so they can get an authorization for 120 days. Providers can also get an authorization up to 90 days before someone is in housing but again they've got to be chronically homeless and working with a case manager towards housing. It's not about just billing for the service and someone is terminally homeless. That's not the point. That's how it works from that perspective.

It costs about \$6,300 and again that gives providers resources to pair with housing. In FY15 we spent about \$2.38 million and the average length someone has been given services is 2.2 years. One thing that's come up in conversations I've had with Steve and Melanie before this webinar is the issue of dual eligibility. We're still working on that in Massachusetts. If someone gets Medicare then they are no longer served by MBHP so that's a little bit of a glitch because once they're housed and stable and they get the services they need, maybe SSI, then all of a sudden they lose this benefit that has allowed them to stabilize. So we're really working on that here.

I want to stress with this data that this was small, I think 295 people involved in this study. A very small internal study. This is not gospel truth. But it gives you a sense of just these dramatic reductions that we're seeing. So this is based on actual claims data. So behavioral health went down if you look in the first column from \$12,000 to \$10,000. If you look at the utilization, that went down as well. The medical processing estimate, that's from the Massachusetts Housing and Shelter Alliance and it's based on Boston Healthcare for the Homeless data so the total on the bottom right, the estimate is around \$25,000. Of course that's savings but then of course there's a cost to the service. The average cost, housing and services, MHSA estimates about \$15,000. It's probably creeping up closer to \$18-20,000 now. Again that's everything, housing and services. When you look at the cost of somebody on the streets – take cost out of it, just their health in general – versus once they get into housing, it's just dramatic what we see. We're looking at a net savings of about \$10,000 per person annually. Again, if you extrapolate out that's \$3 million a year in savings.

This is a really interesting slide. This is an ED utilization comparison. Nine out of 10 had a decrease and a very significant decrease at that. Even if you look at member one, the first column 106, and then during their second year of CSPECH it goes down to 10. Even just looking down the first column it's all double digits and then the second column especially in the lower half it gets lower and lower. So the total went from 300 to 80, so that was about a 73% decrease.

That's the quick overview of CSPECH. It's just a billable service that's covered. It's in our capitation. It's not anything special. It's just something that providers can call and get an authorization for. Larry can talk about CSPECH from a provider perspective.

Larry Gottlieb (LG): I'm the Director of Homeless Services for a large behavioral health organization in Massachusetts called Eliot Community Human Services. We have about 1600 employees. Our homeless program is statewide. We're the PATH provider for our state. We're the single provider, PATH provider. Massachusetts is very unique, has one provider. So we're in about 50 locations and we are a provider of

direct services to homeless clients, and we're only talking about chronically homeless adults. We don't do family work. Almost all the family work is done here through two different agencies, our Dept. of Transitional Assistance and our Dept. of Housing and Community Development. It's a closed system. We're talking about single adults.

We provide both outreach and in-reach to homeless individuals in about 50 locations who are largely in emergency shelter or living on the streets or places not meant for human habitation. We operate within the broader mental health division here at Eliot. We have a number of outpatient clinics in a variety of locations. We do lots of work with our state mental health authority, which as most of us know is the recipient of PATH funds that get distributed to our state.

We are a licensed clinical agency, which allows us to bill our Medicaid managed care entities. As Erin mentioned, we have five or possibly six managed care entities. It covers about 1.2 million people here in Massachusetts. Those who work in the homeless realm know that Massachusetts in 2014 had the 5<sup>th</sup> highest number of homeless among the states. That includes families and individuals, and our state has a population of about 6.6 million people and it's very cold here, so lots of our clients we serve are in many different places in terms of sheltering. It's virtually impossible to live in Massachusetts in the wintertime and be outside although we do have some rough sleepers.

More recently we have contracted with the MSHA for a SIF or pay for success model, which over the next two years is targeting about 800 additional chronically homeless folks for these CSPECH type benefits and this is now including all of our managed care entities. So we started out with Erin's organization, Mass. Behavioral Partnership under the carve-out, and now we've expanded under pay for success to all our other managed care entities. It's a rate between \$17 and \$17.5 a day seven days a week. The agencies we work with are many times receiving HUD CoC dollars. We have 16 CoC's here in Massachusetts. A small state, lots of advocacy on the CoC level. So our partners are shelter providers, some affordable housing providers, and we are now billing for about 275 clients who are permanently housed. You can see from the slide: 113 are in the pay for success program and 162 in CSPECH. That's just Eliot. There are other agencies who can do third-party billing. Some of our shelters have licenses to do that but we're working with a number of entities who cannot do the billing because they're not licensed, so we have the capacity in our billing department to do that. We have a very simple system to gather the information.

There has to be a diagnosis as Erin described. If it's in the behavioral health program, many of our managed care entities partner with a number of behavioral health organizations in order to provide behavioral health services and right now CSPECH is totally in the realm of behavioral health, so a DSM-5 diagnosis is required. Again as Erin mentioned the agencies we work with, we can start working with people pre-housing and the amount, intensity and acuity of the service really depends on the individual. Once the housing is identified, a case manager might be spending much more time with an individual, working with a landlord, providing assistance for a variety of benefits, again like Robin said under a very low threshold environment. It's not a requirement for a person to be engaged in mental health or addiction treatment in order to get into the program. That's really the work of a case manager is to get both connected with benefits and other clinical supports.

Erin mentioned that because of our situation here with dual eligibles that some of our folks who become SSDI-eligible and achieve a Medicare benefit, that terminates the CSPECH benefit. We're working with our state Medicaid office to change that because it does impact a number of clients we work with who have been housed. They're in the programs, they're getting services, and after the two years of receiving

their SSDI benefit they achieve Medicare and become ineligible so that's something we're working on fixing here.

In terms of the housing, again Massachusetts has 351 cities and towns. We have about 240 PHAs here in a very small state. We work with many of our housing authorities, but a lot of the housing that's actually put up by our partners comes from their own access to some state voucher programs. We call it the Mass. rental voucher program, the Section 8 programs, for the clients to get access to the housing. My staff are largely clinicians working in the shelters so often my staff have become familiar with many of the clients being targeted for permanent housing. We can provide a lot of consultation and support to folks as they prepare for housing. So there's a nice continuity between what we're doing kind of at the grassroots level, whether it's outreach or in-reach in shelters, and clients get handed off to case management for long-term services. I was really impressed with Robin's numbers. Ninety-four percent of clients staying successfully housed here in Massachusetts, rates across the state are somewhere between 80-85% and in some cases a little bit higher, so the results are dramatic. Of course again, we have a \$40 billion budget here in Massachusetts for our state and \$15.5 billion of the 40 is in the Medicaid program or MassHealth program, which is about 40% of our entire budget. It's not a sustainable number. Most of what we're trying to do is redirect care to more appropriate outpatient services, shift people away from emergency care. Get them connected to ongoing behavioral health, substance abuse disorder and medical services.

I've been here in Massachusetts the last 18 years and involved with Healthcare for the Homeless as director. We have six Healthcare for the Homeless grantees here. We're really making a push to get folks connected to permanent housing and services and keeping people in more appropriate levels of care and try to reduce our total cost. The biggest problem here is in terms of housing. Housing is super expensive here in Massachusetts. Finding landlords who are even willing to take some of our vouchers has been a challenge. Most of the cheaper housing in our state is now being developed for market rate housing. Lots of people come here to go to school and stay on, to live here permanently, so that's been the biggest challenge. But our partners are usually creative in terms of their ability to create some additional housing, attach clients to vouchers for our folks who are largely on some type of disability benefit. Our state actually has a general assistance program which is of very low financial benefit. But we're seeing some great results from CSPECH and our PSH programs and we hope to continue.

ED: I'll wrap it up. CSPECH, Larry summed it up where it's about redirecting, about better care at a lower cost for a very vulnerable population. So it's really a clear way to obtain the goals of triple aim – better quality, better care, reduced cost. We do have data showing that the majority of members reported much improvement in their lives. We did win back in 2010 – you can Google Pioneer Institute Better Government Competition 2010, and you'll see the whole paper. We won the grand prize. You'll see the whole paper that explains CSPECH in more detail and perhaps organizers can send that out as well. It's just a PDF.

The keys to success are we've heard that throughout the day. It's really the vision and the support of the state leadership. That was key that we had that support. The direct involvement of the consumers and the providers. They were there at the table at the beginning. Then really building those partnerships between the housing agencies and the healthcare agencies and Medicaid, and just bringing everybody together to the table and not bridging that abyss and just hammering home the message that housing is healthcare, and that's really what it's about. That sums it up.

SE: Thanks. Two questions on CSPECH. First, even though the services are not clinical services is there a clinical supervision requirement?

ED: They are required to be supervised by a licensed Master's level clinician so there always is a Master's level person kind of overseeing the case. So yes.

LG: That's part of the standards that the MBHP created with CSPECH initially so the clinical person is the backup and support, because the training for the folks actually providing the services varies, including people with lived experience all the way up to people with a Master's degree. But often that support is needed, folks dealing with serious mental illness, so yes, it's a really important component of the overarching services that are part of CSPECH.

SE: A question around vouchers. How are you getting by with using vouchers for people with a bad background history?

LG: Because a lot of the housing that we're talking about when people are placed out of shelter or even sometimes directly from the streets is managed by the shelters themselves, and sometimes working with private landlords, we have a very forgiving system around placing people with bad criminal records. Obviously we have concerns about very violent offenders and so forth but generally, unlike the PHAs, which have some stiff requirements around background checks and so forth, we're often dealing with more of a private landlord, and because they know they can count on the services being present, when they're willing to take some folks that have a checkered past they're much more willing to work with our partners, ourselves because they know they can turn to an agency that's going to be present in the event that there are issues that may arise.

SE: I'll check with our housing colleagues not on the line but I believe there are local PHAs that have standards more strict than the federal standards and there may be flexibility with your PHA. I'll loop back with our housing experts that are part of the partners and the program support team.

One last question for both states. The questioner states the strategies seem to be aimed at single adults, especially people who have experienced chronic homelessness. Are there strategies for people not chronically homeless, such as in relation to an opioid or heroin crisis?

LG: Because we have so much data on how expensive serving the chronically homeless population is here in Massachusetts where healthcare costs are probably higher than most places around the country, the real target has been on the chronically homeless for this particular program. We have been really focusing on this chronic population. The pay for success program, which is a variation on this theme, does a vulnerability index screening. So the length of homelessness in the PSH program, they put a little different spin on it but they're still looking at domains that indicate high utilization of emergency departments, ambulance trips, detox, mental health services. A person being targeted for PSH could have a less than chronic homeless history but because of the screening that goes into getting into our housing advocacy agency Erin mentioned, the Mass. Shelter and Housing Alliance, they have a screening tool and say pass or fail based on a score on that. So that gives the non-chronics a little bit of an opportunity to get permanent housing, which is a good thing for folks that have a lot of factors that contribute to high costs and high spend in terms of all their needs.

SE: Next steps: Final webinar April 27<sup>th</sup>, 2:30-4:30 Eastern. Focus on implementation planning based on lessons learned from experienced states. We can have additional calls with small groups of states on particular topics of interest, i.e. the Crosswalk. If there is interest from states, we can have a call about

that. We can give support you need to get things together. There is a fair amount of interest of how to make the services work and as folks have specific questions, let me know.

One more polling question: What do you expect to be the most difficult when implementing Medicaid housing services? There's a variety of options: having provider capacity, provider billing – getting good providers able to bill for health-related services, working with MCOs, provider standards, rate-setting, measuring cost savings, measuring outcomes, prompt start of service especially for individuals, getting individuals ready for service, or other aspects. I see a lot of results for rate-setting. Along with provider capacity and a fair amount of others used startup service.

Please E-mail me with additional questions. Put “tenancy” in the subject line. Thanks to all the presenters today. Please fill out the webinar survey after the webinar.