

Medicaid's Role in Housing

The relationship between housing and health is well established. Poor housing conditions can worsen health outcomes related to infectious and chronic disease, injury, and mental health, and may also affect childhood development through exposure to harmful toxins such as lead. Individuals experiencing homelessness or housing instability (for example, difficulty paying rent or frequent moves) also have difficulty obtaining health care and managing complex health conditions. Recent data suggest that among those who are chronically homeless, the provision of supportive housing—not increased access to case management or other outpatient health services—led to a decrease in emergency department use (Moore and Rosenheck 2017).

Medicaid and supportive housing programs serve many of the same individuals, yet collaboration between the two has been limited in the past. As states focus attention on addressing social determinants of health, however, Medicaid programs are increasingly collaborating with state and local housing authorities to assist beneficiaries in need of supportive housing.

This issue brief describes how Medicaid programs pay for housing-related services. It begins by reviewing relevant subregulatory guidance issued by the Centers for Medicare & Medicaid Services (CMS) and the various federal Medicaid authorities under which states can cover housing-related services. It provides examples of how certain states braid multiple funding sources to provide supports for certain populations, and also discusses the use of health services initiatives (HSIs) under the State Children's Health Insurance Program (CHIP) to identify lead exposure and fund abatement.

Federal Guidance on Use of Medicaid Funds for Housing

Medicaid programs currently can pay for housing-related services that promote health and community integration such as assistance in finding and securing housing, and home modifications when individuals transition from an institution to the community. However, Medicaid cannot pay for rent or for room and board. CMS has issued three pieces of related guidance on housing-related services since 2012. Described below, these focus on supporting states' ability to comply with legal rulings to promote community integration for people with disabilities; approaches for providing housing-related activities or services to specific populations; and ways in which states can reduce lead exposure for low-income children.

Resources to support Olmstead implementation

In its 1999 *Olmstead v. L.C.* ruling, the United States Supreme Court held that the unjustified institutionalization of individuals with disabilities was a violation of the Americans with Disabilities Act (ADA, P.L. 101-336).¹ Under the ADA, people with disabilities are guaranteed equal opportunity to access



all public programs, including the right to live in the most integrated setting appropriate to their needs. Medicaid supports community integration as the primary payer of long-term services and supports (LTSS).

In 2012, CMS issued an informational bulletin to states highlighting housing resources that could be used in coordination with Medicaid to support Olmstead implementation, including the Section 811 Project Rental Assistance (PRA) program. This program, run by the U.S. Department of Housing and Urban Development (HUD), provides integrated supportive housing for people with disabilities (CMS 2012). PRA funds are awarded to state housing agencies that set aside units in affordable housing developments whose capital costs are funded through federal low-income housing tax credits, federal HOME Investment Partnerships Program funds, or other state, federal and local funding sources. In order to receive PRA funds, state housing grantees are required to partner with state Medicaid programs to identify and refer low-income individuals with disabilities to PRA units and ensure their access to LTSS within the community (HUD 2018).

Housing-related services and activities

In 2015, CMS released an informational bulletin to clarify circumstances under which Medicaid funds can be used to pay for certain housing-related activities. These fall into three categories: individual housing transition services; individual housing and tenancy sustaining services; and state-level housing-related collaborative activities (CMS 2015) (Table 1). States can use a number of different waiver authorities to cover these services.

TABLE 1. Medicaid Housing-Related Activities and Services

Housing-related service or activity	Definition	Examples
Individual housing transition services	Direct support is provided to individuals with disabilities, older adults needing LTSS, and those experiencing chronic homelessness.	<ul style="list-style-type: none"> • assisting with housing application process and housing search process • developing an individualized housing support plan • conducting a tenant screening and housing assessment that identifies the beneficiary's preferences and barriers related to successful tenancy
Individual housing and tenancy sustaining services	Services that support individuals to maintain tenancy once housing is secured. These services can be ongoing.	<ul style="list-style-type: none"> • education and training on the role, rights, and responsibilities of the tenant and landlord • assistance with the housing recertification process • advocacy and linkage with community resources to prevent eviction when housing is or may be potentially become jeopardized

TABLE 1. (continued)

Housing-related service or activity	Definition	Examples
State-level housing-related collaborative activities	Strategic and collaborative activities to assist in identifying housing resources.	<ul style="list-style-type: none"> • developing formal and informal agreements and relationships with state and local housing agencies to facilitate access to housing resources • working with housing partners to create and identify opportunities for additional housing options for people wishing to transition to community-based settings • participating and contributing to planning processes for state and local housing agencies

Notes: LTSS is long-term services and supports.

Source: CMS 2015

Lead abatement

In 2017, CMS released a set of frequently asked questions on HSI funds that states can use to pay for certain public health activities, including lead abatement. Permitted lead abatement activities include the removal, enclosure, or encapsulation of lead-based paint and lead dust hazards; the removal and replacement of surfaces or fixtures, which can include water service lines and other fixtures identified during an environmental investigation as lead hazards; the removal or covering of soil lead hazards; and training to ensure there is a sufficient number of qualified workers to complete the lead abatement activities (CMS 2017).

Relevant Medicaid Authorities for Covering Housing-Related Services

States can use several different federal authorities to pay for housing-related services, particularly for individuals transitioning to the community from institutional settings. This section describes various authorities and provides examples of how states use waivers to provide housing supports and services.

Money Follows the Person demonstration

The Money follows the Person (MFP) demonstration, authorized by the Deficit Reduction Act of 2005 (DRA, P.L. 109-171), provided \$3.7 billion to 43 states and the District of Columbia to help Medicaid beneficiaries transition from institutions back to the community. To be eligible, participants must be Medicaid beneficiaries residing in an institution for 90 days or more, not counting short-term rehabilitation days.² Beneficiaries receive additional home- and community-based services (HCBS) under the demonstration beyond what is provided under a state's existing HCBS programs, including housing supports.



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MFP states have also partnered with public housing authorities to provide housing choice vouchers to beneficiaries that can be used to secure housing within the community.³ More than 63,000 people with chronic conditions and disabilities transitioned from institutions back into the community through MFP programs between 2008 and 2015. Although states can continue to transition beneficiaries through December 31, 2018 and claim federal financial participation through fiscal year (FY) 2020, the authorization for the MFP program expired on September 20, 2016.⁴ Congress is considering legislation to extend MFP funding.⁵

Section 1115 waiver demonstrations

A few states have covered housing-related activities or services for Medicaid beneficiaries through Section 1115 waiver demonstrations. Such demonstrations are initially approved for five years and must be budget-neutral, meaning that federal spending under the waiver cannot exceed what it would have been in the absence of the waiver. Three states (Delaware, Hawaii, and Maryland) provide supportive housing services as part of Section 1115 waivers that expand community-based behavioral health benefits (Musumeci 2017).

Under the Medi-Cal 2020 demonstration, the state of California provides housing supports to certain beneficiaries through its Whole Person Care pilots (California DHCS 2016).⁶ Depending on the design of the pilot program, eligible beneficiaries can receive housing-based care management and tenancy supports including assistance in finding and securing housing, coverage for certain move-in costs, and minor home modifications. These services are targeted to individuals at risk of or experiencing homelessness and those with a demonstrated medical need for housing and supportive services, such as individuals with behavioral health needs. There are 14 pilot programs that address homelessness, and they coordinate with managed care organizations, the public housing authority, and community organizations to deliver services. Pilot programs may also connect beneficiaries to permanent housing opportunities through the use of a county-wide housing pool (Pagel et al. 2017).⁷ Los Angeles County administers the largest Whole Person Care pilot program which is estimated to serve 150,000 individuals over five years (California DHCS 2017).⁸

Section 1915(b) managed care waivers

States can use savings achieved under Section 1915(b) waivers to provide additional services, including housing-related services to beneficiaries enrolled in managed care. In some states, this includes housing-related services to help beneficiaries with disabilities, older adults needing LTSS, and those experiencing chronic homelessness to identify, transition to, and sustain housing. For example, under a Section 1915(b) waiver, North Carolina offers Medicaid coverage for supportive services that help individuals with serious and persistent mental illness transition into the community. Individuals with mental health needs or substance use disorders (SUDs) may use peer supports as part of individualized recovery services aimed at developing skills for housing, employment, and self-management. The waiver also specifically provides the authority for Medicaid coverage of transitional living skills such as housekeeping, shopping, and laundry services for children under age 21 with certain behavioral health diagnoses (CMS 2013a).



Section 1915(c) home- and community-based services waivers

States may use Section 1915(c) waivers to pay for housing transition and tenancy-sustaining services for beneficiaries who would otherwise be served in settings such as a nursing facility. These include the costs of services needed to establish a basic household such as environmental modifications, security deposits required to obtain a lease, moving expenses, and essential household furnishings.⁹ Such services may only be provided to the extent that they are reasonable and necessary as determined through development of the beneficiary's service plan and only when the beneficiary is unable to meet the expenses or obtain the services elsewhere.¹⁰

At least six states use Section 1915(c) waivers to deliver housing-related services such as supports to transition into community-based living, home modifications, and one-time moving expenses (Jopson and Regan 2016).¹¹ For example, the Louisiana Department of Health, in partnership with the state's housing authority, operates a permanent supportive housing program financed through multiple federal and state funding streams, including Medicaid.¹² Multiple Section 1915(c) waivers help the state provide pre-tenancy, tenancy crisis, and tenancy-maintenance services, whereas Medicaid state plan services focus on mental health rehabilitation, including community psychiatric supportive treatment and psychosocial rehabilitation.

Individuals must have a substantial, long-term disability (which may be physical, developmental, or behavioral) and be in need of housing and tenancy support to participate in Louisiana's supportive housing program.¹³ Eligibility is not limited to Medicaid beneficiaries though many are served by the program; Medicaid pays for tenancy supports for 67 percent of program participants (CSH 2017).

By contrast, Minnesota uses four different Section 1915(c) waivers to provide HCBS to individuals with traumatic brain injuries, developmental and physical disabilities, and the chronically ill. Waiver services and supports help Medicaid-eligible individuals transition into community living and include coverage for certain moving expenses, assistance in finding a home, a housing plan, and building skills in how to be a tenant and negotiate with landlords. Minnesota also covers home modifications such as wheelchair ramps, widening doors, and stair lift installation, limiting payment for eligible modifications to \$40,000 per beneficiary per service year (Jopson and Regan 2016).

Many states use Section 1915(b) waivers jointly with Section 1915(c) waivers. For example, Ohio implemented joint Section 1915(b) and 1915(c) waivers to provide housing supports for individuals age 18 years and older who are eligible for Medicare and Medicaid, require a nursing facility level of care, and reside in a participating county.¹⁴ Covered services to facilitate home-based living include home modifications up to \$10,000 and home medical equipment (CMS 2013b).

Section 1915(i) home- and community-based state plan benefit option

Section 1915(i) of the Social Security Act (the Act) allows states to offer housing-related services that are similar in nature to those offered under Section 1915(c); however beneficiaries do not have to meet an institutional level of care and the state cannot place a limit on the number of individuals served.



States may use this option to provide housing-related services to adults with behavioral health conditions, or those who would not otherwise qualify under a Section 1915(c) waiver. Texas uses this authority to pay for home modifications, transition assistance, and long-term recovery support services for adults with serious mental illness. Services include minor home modifications, transition assistance, supervised living services, and supportive home living (Texas DSHS 2016).

Section 1905(a) state plan services

Section 1905(a) of the Act gives states the authority to provide services under their Medicaid state plans for individuals transitioning from institutions, or trying to obtain or maintain housing in the community. An example of such a service includes targeted case management, which can assist beneficiaries in gaining access to needed medical, social, educational, and housing services. Typically, case managers work with beneficiaries to assess their needs, devise a plan, and either provide services or connect them to resources for other non-covered services. Case managers are required to monitor and follow-up with beneficiaries on their progress.

In Minnesota, case managers help clients reach housing services and resources, often by connecting them to specialized agencies and organizations (Minn. Stat. § 245.462 (2017)). The state of Connecticut offers targeted case management to individuals with SUDs and co-occurring mental illness to help beneficiaries find a place to live or keep current housing, and to assist in monitoring their budgets to ensure they can maintain their housing, though providers do not directly budget for an individual or pay bills on behalf of the beneficiary (Connecticut DMHAS 2017).

Section 1915(k) Community First Choice state plan optional benefit

Community First Choice (CFC), authorized under Section 1915(k) of the Act, allows state Medicaid programs to pay for services and supports to pay for services identified as a part of person-centered care plans. Such plans are developed with the beneficiary and document the specific type of care the beneficiary will receive (CMS 2015).

Under CFC, states including Oregon and Maryland may cover transition costs for individuals moving from an institution to a home or community-based setting, including security deposits for an apartment or utilities, basic bedding or kitchen supplies, and other one-time expenses. CFC may also cover costs related to home modifications when specified in an individual's person-centered care plan as necessary to increase independence or substitute for human assistance. As of March 2016, eight states—California, Connecticut, Maryland, Montana, New York, Oregon, Texas, and Washington—were using Section 1915(k) state plan authority (Watts and Musumeci 2018).

Health Services Initiatives

States can use CHIP funding to implement health services initiatives (HSIs) that improve the health of low-income children under the age of 19 who are eligible for CHIP or Medicaid (42 CFR 457.10).¹⁵ HSIs must directly address the health of children eligible for Medicaid or CHIP but may serve children regardless of



household income (CMS 2017). States are also encouraged to use an approved HSI to enroll eligible but unenrolled children in Medicaid or CHIP.¹⁶

Generally, the HSIs approved by CMS have addressed services related to public health interventions and prevention, for example poison control and youth violence prevention (CMS 2017). However, some states, including Michigan and Maryland, are using HSIs to address and reduce childhood lead poisoning including through lead abatement activities.¹⁷ States seeking approval to implement such activities must meet certain criteria such as using state-certified individuals to perform abatement services and demonstrated effectiveness of activities in removing lead hazards. The program must be time-limited. Because there are no statewideness requirements for CHIP, states may target their lead abatement programs to specific communities that have been heavily affected by lead exposure.

To respond to crisis associated with lead tainted water in Flint, Michigan, the state received approval in 2016 for a Section 1115 demonstration to expand Medicaid coverage for pregnant women and children who were served by the Flint water supply between April 2014 and a date to be determined in the future.¹⁸ To complement that demonstration, CMS approved an HSI that authorizes \$24 million per year for five years to reduce lead hazards in Flint and other parts of the state. Activities approved under the HSI include removing lead-based paint and lead dust hazards; removing and replacing surfaces or fixtures identified as lead hazards; removing or covering soil lead hazards; pre- and post-abatement testing activities; and workforce training (CMS 2016).

Maryland's Medicaid program partnered with the Department of Environment and the Department of Housing and Community Development to implement an HSI in state fiscal year 2018 to reduce lead poisoning and improve asthma treatment. The HSI's two-pronged approach includes expanded lead identification and abatement, and environmental case management for certain Medicaid and CHIP beneficiaries. Children under the age of 19 who are enrolled in or may be eligible for CHIP or Medicaid and who have an elevated blood lead levels are eligible for services. Properties in which an eligible child resides or spends more than 10 hours a week can be assessed for the presence of lead. This includes rental properties, owner-occupied properties, and residential day care facilities. If a presence of lead is found, a lead abatement contractor will remediate the property and abatement will be confirmed by a lead inspector. In select jurisdictions, children enrolled in or eligible for Medicaid and CHIP who are diagnosed with persistent moderate to severe asthma and those with elevated blood lead levels are able to receive additional case management services (Maryland DOH 2017).

Endnotes

¹ *Olmstead v. L.C.*, 119 S. Ct. 2176 (1999).

² For purposes of the demonstration, institutions include nursing homes, intermediate care facilities for individuals with intellectual disabilities, institutions for mental diseases for individuals 65 and older, inpatient psychiatric facilities for individuals under the age of 21, and hospitals (HHS 2017).



³ The housing choice voucher program, commonly referred to as Section 8, is the federal government's program for assisting low-income families, people over age 65, and people with disabilities to receive safe housing in the private housing rental market (CMS 2012). In 2011, HUD allocated housing choice vouchers to 28 public housing authorities in 15 states. Housing authorities were required to partner with its state health and human services agency or the state Money Follows the Person demonstration program (Lipson et al. 2014).

⁴ In a [March 2018 letter](#) to the chairmen and ranking members of the Senate Finance and House Energy and Commerce Committees and the Secretary of the U.S. Department of Health and Human Services, MACPAC commented on the Secretary's final report on the MFP demonstration program (MACPAC 2018).

⁵ Ensuring Medicaid Provides Opportunities for Widespread Equity, Resources, and Care Act (EMPOWER ACT), H.R. 3728, 115th Cong. (2017).

⁶ The demonstration provides up to \$3.0 billion for the pilot, \$1.5 billion of which come from federal Medicaid matching funds and \$1.5 billion from local funds provided through intergovernmental transfers. To participate in the pilot program, lead entities—which are usually county government agencies—must apply to the California Department of Health Care Services. Lead entities are required to work with other community organizations including managed care plans and the public housing authority to demonstrate how non-Medicaid covered services, such as room and board, will be paid for under the pilot (California DHCS 2017a).

⁷ A flexible county-wide housing pool is one suggested way to pay for housing under the pilots. This pool may include Whole Person Care pilot payments for housing-related deliverables for which Medicaid payment is available, as well as assistance such as rental subsidies that are not eligible for federal Medicaid matching funds (CMS 2018).

⁸ The program includes five types of services to help homeless participants with medical needs gain access to housing. The five services are homeless care support services; recuperative care, which includes the provision of short-term residential care for homeless participants in need of housing and supports while they recover from acute illnesses or injuries; sobering centers; tenancy support services; and benefits advocacy, which includes social supports and enrollment assistance for public benefits (LACDHS 2017). ⁹ CMS has also clarified that expenses for services to help establish a household may be paid for individuals transitioning out of Medicaid-funded institutions or other provider-operated arrangements into a private residence where the beneficiary is responsible for his or her own living expenses (CMS 2015).

¹⁰ Service planning for beneficiaries in programs authorized under Sections 1915(c) and 1915(i) of the Social Security Act (the Act) must be person-centered and address health and LTSS needs in a manner that reflects an individual's preferences and goals. The service planning process is directed by the beneficiary and may include a representative that the individual has freely chosen to contribute to the process. A person-centered plan includes individually identified goals and preferences, such as those related to community participation, employment, income and savings, health care and wellness, and education. The plan should reflect the services and supports the beneficiary receives (paid and unpaid), who provides these services and whether the beneficiary chooses to self-direct services.

¹¹ Alabama, California, Connecticut, Louisiana, Minnesota, and Wisconsin provide coverage for housing services and supports through a combination of 23 different Section 1915(c) waivers, with some variability in the type and scope of services (Jopson and Regan 2016).

¹² Other federal funding streams that support Louisiana's housing partnership include grants from the Health Resources Service Administration (HRSA), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Veterans Administration (VA) (Wagner 2017).



¹³ Priority is given to individuals transitioning from institutions and homeless individuals or households (CSH 2017).

¹⁴ Ohio's Section 1915(b) waiver mandates enrollment in managed care for eligible beneficiaries, though beneficiaries may opt out of the plan for Medicare benefits. The state's Section 1915(c) waiver outlines the covered services (CMS 2013b).

¹⁵ For the purposes of an HSI, low-income child means a child whose household income is at or below 200 percent of the federal poverty level (CMS 2017).

¹⁶ Section 2105(a)(1)(D)(ii) of the Act gives states the option to use CHIP funds to develop an HSI to improve the health of low-income children through direct services or public health initiatives (CMS 2017b). HSIs are funded through the states' CHIP allotments, but are subject to the same cap applicable to administrative expenses: 10 percent of the total amount states spend on CHIP health benefits. States must first fund their administrative costs; after that any remaining funds under the cap can be used for HSIs. States receive the CHIP matching rate for HSIs.

¹⁷ Lead poisoning has severe implications on childhood development. It can lead to behavioral, endocrine, and cardiovascular conditions, as well as learning difficulties and a decline in IQ. All children enrolled in Medicaid are required to receive blood lead screening tests at ages 12 months and 24 months. Moreover, any child between age of 24 and 72 months with no record of a previous blood lead screening test must receive one. Separate CHIP programs do not have the same requirements for universal lead screenings as Medicaid, although states are encouraged to align their CHIP and Medicaid screening policies (CMS 2017).

¹⁸ Michigan's Section 1115 demonstration expanded coverage for pregnant women and children up to age 21 with incomes up to and including 400 percent of the federal poverty level (FPL). Those with incomes over 400 percent FPL may buy into the program to receive full Medicaid benefits (CMS 2016).

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