March 10, 2021

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The Honorable Mike Crapo
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The Honorable Frank Pallone Jr.
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The Honorable Norris Cochran
Acting Secretary
U.S. Department of Health and Human Services
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Re: Report to Congress on Innovative State Initiatives and Strategies for Providing Housing-Related Services and Supports under a State Medicaid Program to Individuals with Substance Use Disorders (SUD) Who Are Experiencing or at Risk of Experiencing Homelessness

The Medicaid and CHIP Payment and Access Commission (MACPAC) is pleased to comment on the U.S. Department of Health and Human Services (HHS) report, *Innovative State Initiatives and Strategies for Providing Housing-Related Services and Supports under a State Medicaid Program to Individuals with Substance Use Disorders (SUD) Who Are Experiencing or at Risk of Experiencing Homelessness.* MACPAC is required by statute to review HHS reports to Congress and provide written comments to the Secretary and appropriate committees of Congress.

The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act, P.L. 115-271) directed the Secretary to report on innovative state strategies for providing housing-related services and supports in Medicaid to individuals with SUD who are experiencing or at risk of experiencing homelessness. The law also

called for a description of federal Medicaid authorities that states may use to cover housing-related services and supports for this population and lessons learned specific to the use of Sections 1115 and 1915 of the Social Security Act (the Act). Additionally, the Secretary was required to identify strategies used by Medicaid managed care organizations (MCOs), hospitals, accountable care organizations (ACOs), and other care coordination entities to provide housing-related services and supports, as well state Medicaid program efforts to identify and enroll eligible individuals with SUD who are experiencing or at risk of experiencing homelessness.

Report Summary

The report identifies relevant federal authorities and other opportunities states can pursue to provide services that may help Medicaid-eligible individuals with SUD who are experiencing or at risk of homelessness access and maintain housing. Those most commonly cited in the report include Section 1945 health homes, Section 1915(b)(3) waivers, Section 1915(c) waivers, Section 1915(i) state plan authority, and Section 1115 demonstrations.[1]

The report describes broad strategies used in five states (Arizona, California, Maryland, Pennsylvania, and Washington) to provide housing supports to beneficiaries with SUD who are experiencing or at risk of homelessness. These include the use of Medicaid-funded peer support services, technical assistance to health and housing providers, and multidisciplinary care coordination to address housing, medical, behavioral, and social support needs. Because of limitations on the use of Medicaid funds, programs must coordinate multiple federal, state, local, and philanthropic sources to address needs for rental assistance, affordable housing options, and other services and supports not covered by Medicaid.[2]

A key finding of the report is that states face challenges when using federal Medicaid authorities to design housing-related services for individuals with SUD. These include developing and strengthening partnerships at the federal, state, and local levels, and selecting the appropriate Medicaid authority. While Section 1915(c) waivers are a major vehicle for providing home- and community-based services (HCBS), few states use them to pay for supportive housing for this population. This is partly because such waivers can only be used for Medicaid-eligible individuals who need an institutional level of care, and many individuals with SUD do not meet this criterion. States are increasingly using Section 1915(i) state plan authority, though some have reported challenges defining eligibility such that they could create highly targeted programs for those experiencing or at risk of experiencing homelessness.

The report also discusses strategies used by plans and providers to support this population, as well as strategies to facilitate their enrollment in Medicaid. Many MCOs, hospitals, ACOs, and other care coordination providers are focused on expanding services to improve health outcomes for high-cost, high-need Medicaid beneficiaries, including those with SUD, while also managing costs. States are also undertaking innovative efforts to identify, engage, and enroll individuals experiencing homelessness in Medicaid, many of whom have SUD.[3]

The report concludes by noting that homelessness is strongly correlated with SUD. States are testing a variety of approaches to address the housing needs and health status of individuals with SUD, most often under Section 1115 demonstrations. While the initial results of these efforts are promising, full evaluations of these demonstrations are not yet available.

MACPAC Comments

Medicaid can play an important role in addressing social factors, such as housing, that affect the health of its beneficiaries. Simply having Medicaid coverage can improve housing stability by reducing the financial burden of medical care on beneficiaries and their families (Allen et al. 2019, Zewde et al. 2019). The report highlights the various ways Medicaid can pay for pre-tenancy and tenancy-sustaining services for individuals who are experiencing or at risk of homelessness, including those with SUD, as well as certain activities that promote coordination with other public agencies.[4] However, Medicaid housing-related services are only one part of the solution. As the report notes, a range of federal, state and local agencies; community-based organizations; and other partners are needed to provide rental assistance, increase affordable housing options, and provide non-Medicaid services and supports needed to help individuals acquire and maintain stable housing.

The report is useful in understanding the role and limitations of Medicaid in addressing housing stability for individuals with SUD. It also provides insights into challenges states are experiencing when serving beneficiaries with SUD, including those that are outside the scope of Medicaid policy. The report is also particularly timely, given recent increases in housing instability and rates of SUD resulting from COVID-19 and the economic recession.

Below we comment on barriers and identify opportunities for federal policymakers to address them. We also discuss the need to consider racial and ethnic disparities in future reporting. Although the report focuses on SUD, as required by the SUPPORT Act, our comments also apply to beneficiaries with other behavioral health needs. There is a high prevalence of mental illness among individuals who are experiencing or at risk of homelessness, many of whom have co-occurring SUD and significant physical health needs (SAMHSA 2011).

Additional guidance

The report highlights the difficulty that states face in determining the appropriate Medicaid authority to provide housing-related services to individuals with SUD. There are many different options—each with its own flexibilities and limitations. The best choice for a state also depends upon certain state-specific factors, such as the number of beneficiaries and geographic areas it is seeking to serve. As the report notes, states often provide housing-related services as part of a broader benefit that may include other HCBS, such as supported employment. However, previous federal guidance, including recent guidance on

social determinants of health, do not provide a comprehensive road map for designing an HCBS benefit geared toward individuals with SUD and mental health conditions (CMS 2021, CMS 2018, CMS 2017).[5]

The Commission encourages the Centers for Medicare & Medicaid Services (CMS) to coordinate with the Substance Abuse and Mental Health Services Administration, the Office for Civil Rights, and the U.S. Department of Housing and Urban Development (HUD), as appropriate, to issue guidance on opportunities for Medicaid to provide housing-related services and other HCBS to individuals with SUD and mental illness. Guidance on HCBS for individuals with behavioral health conditions should underscore the role these services play in the continuum of care and help state Medicaid agencies navigate the benefit design process in collaboration with state behavioral health agencies, housing authorities, and others. Guidance could identify strategies for developing cross-sector partnerships and braiding Medicaid with other sources of funding, including state and local opioid settlement funds, to improve housing stability among this population.[6]

The Commission also urges CMS to issue new or revised Section 1115 guidance that discusses the provision of housing-related services for beneficiaries with behavioral health conditions. Although the report notes that states commonly use flexibilities available under Section 1115 to provide housing-related services, current guidance regarding Section 1115 demonstration opportunities for SUD and serious mental illness or serious emotional disturbance provide minimal or no mention of housing-related services (CMS 2018, CMS 2017). As both of these demonstration opportunities facilitate payment for behavioral health care in Institutions for Mental Diseases (IMDs), it is important for guidance to address the housing needs of individuals transitioning from IMDs back into community settings, as well as the role of housing-related services and supports in supporting recovery and community integration.[7] Providing supportive housing could also keep individuals out of IMDs, while maintaining access to community-based treatment.

Racial and ethnic disparities

While the report addresses Congress' mandate, it does not examine how beneficiary needs may vary by race and ethnicity, nor does it address whether state Medicaid initiatives include a focus on equity. These elements were not required under the SUPPORT Act, despite the disproportionate burden of homelessness and behavioral health conditions among certain minority groups.[8]

When contemplating future reporting requirements, Congress should consider requiring the Secretary to note any differences in access and outcomes among racial and ethnic minorities and how policies address health disparities. Individuals of color are more likely to experience homelessness and barriers to behavioral health treatment when compared to their white counterparts. Blacks, for example, represent 13 percent of the general population but account for 40 percent of people experiencing homelessness and more than 50 percent of homeless families with children (HUD 2020). In Medicaid, non-institutionalized Black beneficiaries age 18–64 experience mental illness at twice the rate of white beneficiaries, yet they are less likely to receive treatment than their white counterparts. Similar disparities are observed when comparing rates of mental illness among Hispanic beneficiaries and beneficiaries who report two or more races (SHADAC 2021).

Housing needs of individuals with behavioral health conditions leaving incarceration

As the report notes, more than 10 percent of people released from prisons and jails face homelessness upon reentry; in large urban areas, the share may be as high has 50 percent. Moreover, the prevalence of untreated chronic health conditions, including SUD and mental health disorders, is high among this population. The report references forthcoming guidance on Section 1115 demonstration opportunities to support reentry. This guidance is required under Section 5032 of the SUPPORT Act. In developing this guidance, CMS should highlight how Medicaid can coordinate with state corrections agencies, behavioral health authorities, community-based providers and others to provide housing-related services to Medicaid-eligible individuals with behavioral health conditions as they are leaving prison and jail.[9]

Non-Medicaid barriers to housing stability for individuals with SUD

The report highlights many barriers to housing stability for Medicaid beneficiaries with behavioral health conditions are outside the scope of Medicaid policy, particularly lack of affordable housing. Additional federal support and coordination may be needed to address barriers, including:

- a federally imposed time-limited ban against living in HUD-assisted housing for individuals evicted due to drug-related activities;
- federal policies allowing housing agencies to prohibit or limit housing assistance to individuals who have a past history of drug use or are considered at risk for engaging in illegal drug use; and
- limited funding for rental assistance, which is now available to only one out of every four eligible low-income renter households (HHS 2020, MACPAC 2020).

As MACPAC noted in its June 2018 report to Congress, stigma associated with SUD affects access to care, and can also have serious consequences such as criminal arrest, employment loss, and housing discrimination (MACPAC 2018). Federal regulations (42 CFR Part 2) governing the confidentiality and disclosure of SUD treatment records are intended to prevent stigmatization and concerns that individuals with SUD could be subject to discrimination and other negative consequences. The Coronavirus Aid, Relief, and Economic Security Act (CARES Act, P.L. 116-136) amends the law underlying Part 2 to facilitate sharing of SUD treatment information for the purposes of integrating physical and behavioral health services, while taking steps to enhance enforcement and prevent discrimination. As HHS writes regulations to implement this provision, it should consider the risk of housing loss among the harms that can result from the disclosure of a patient's SUD treatment information.

MACPAC is encouraged by state efforts to use Medicaid funding to provide housing-related services to individuals with SUD. The programs highlighted in the HHS report demonstrate the potential of such services to improve housing stability and reduce the need for care in costly inpatient and other institutional settings. Federal action to support these initiatives and expand access to affordable housing is critical to helping individuals with behavioral health conditions live independently in the community.

Sincerely,

Melanie Bella, MBA
Chair

Cc: Liz Richter, Acting Administrator, Centers for Medicare & Medicaid Services
Anne Marie Costello, Acting Deputy Administrator and Director for the Center for Medicaid & CHIP Services

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Endnotes

[1] Other Medicaid authorities and opportunities described in the report include Section 1905(a) state plan authority, risk based managed care, Section 1915(k) Community First Choice state plan authority, the Money Follows the Person demonstration, integrated care models, and administrative matching funds for certain Medicaid technology investments and Medicaid agency collaboration with other entities working to address beneficiaries' housing needs.

[2] The report notes that Medicaid funds cannot be used to pay for a Medicaid beneficiary's room and board in the community and other benefits that are generally not authorized as home and community-based services. Room and board includes capital funds used for new construction or rehabilitation of housing (CMS 2015).

[3] The report discusses how individuals experiencing homelessness are often disengaged from and distrustful of public systems. Gradual and targeted engagement is needed to establish trust and rapport, combined with individual assistance to navigate the enrollment process for individuals who are Medicaid eligible (HHS 2020).

[4] The report notes that state Medicaid agencies employing individuals to build partnerships and engage in housing collaboration activities may claim the 50 percent administrative match if the state has documented that the costs directly benefit the Medicaid program and are claimed consistent with federal cost allocation principles (HHS 2020).

[5] On January 7, 2021, CMS released a letter to state health officials regarding opportunities to address social determinants of health (SDOH), including housing, in Medicaid and CHIP. The letter is intended to supersede the 2015 CMS informational bulletin on coverage of housing-related services for individuals with disabilities. It does not describe new flexibilities or opportunities to address SDOH, but rather outlines existing flexibilities that states may pursue (CMS 2021).

[6] States, territories, localities, and the federal government have filed lawsuits against pharmaceutical manufacturers and distributors, pharmacies, and consulting firms for their role in the opioid epidemic. Several cases have settled or have settlement talks in progress. A few state legislatures have already begun filing or adopting bills related to the distribution of opioid settlement funds (ASTHO 2021).

[7] Since Medicaid was established in 1965, federal statute has largely prohibited payments to institutions for mental diseases (IMDs). Federal statute defines an IMD as a "hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services (§ 1905(i) of the Social Security Act).

[8] The systemic oppression of certain racial and ethnic minority groups in the United States has contributed to poor health, social, and economic outcomes for many of these communities. Examples include slavery, segregation, and discriminatory housing policies that discouraged economic investment in communities of color (Alliance 2020).

[9] Section 5032 of the SUPPORT Act requires CMS to issue guidance on Section 1115 opportunities to improve care transitions for Medicaid-eligible individuals leaving incarceration within one year of the law's enactment. Such guidance was due to states in October 2019; however as of March 2021, it had yet to be released.

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