

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. 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 (SDOH), however, Medicaid programs are increasingly collaborating with state and local housing authorities to assist beneficiaries in need of supportive housing. The importance of such efforts has been underscored by the COVID-19 pandemic, which has contributed to housing instability, and a growing recognition that communities of color are disproportionately affected by social and economic impediments to health.

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 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, except in certain medical institutions (CMS 2021a). CMS guidance on housing-related services focuses on supporting states' ability to comply with legal rulings to promote community integration for people with disabilities; approaches for providing housing-related services and supports; and ways in which states can reduce lead exposure for low-income children using CHIP HSIs.

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 is 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 can 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. 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 2021, CMS released a letter to state health officials describing circumstances under which Medicaid and CHIP funds can be used to pay for services to address SDOH, including housing-related services and supports. This letter supersedes the CMS informational bulletin on housing-related services issued in 2015.² It does not provide new flexibilities, but outlines how states can address housing (and other SDOH) under existing authorities. The letter describes housing-related services in three categories: home accessibility modifications, one-time community transition costs, and housing and tenancy supports (CMS 2021a) (Table 1). States can use a number of different authorities to cover these services.

TABLE 1. Medicaid Housing-Related Services and Supports

Housing related service or support	Definition	Examples
Home accessibility modifications	Temporary or permanent changes to a home's interior or exterior to help beneficiaries remain in their homes.	<ul style="list-style-type: none"> • installing a wheelchair ramp outside the home • adding grab bars in the shower • enlarging a doorway to allow wheelchair passage
One-time community transition costs	Payment of expenses to establish basic living arrangements when beneficiaries transition from institutional or other congregate settings (e.g., a homeless shelter) to a private residence.	<ul style="list-style-type: none"> • paying security deposits and utility activation fees • purchasing essential household furnishings



TABLE 1. (continued)

Housing related service or activity	Definition	Examples
Housing and tenancy supports	Pre-tenancy services to help beneficiaries transition to housing, and tenancy sustaining supports once beneficiaries are housed.	<p><i>Pre-tenancy services</i></p> <ul style="list-style-type: none"> • conducting a tenant screening and housing assessment that identifies the beneficiary's preferences and barriers related to successful tenancy • assisting with the housing application process and housing search • ensuring that housing units are safe and ready for move-in • assisting in arranging for and supporting move-in, including related transportation and moving expenses <p><i>Tenancy sustaining services</i></p> <ul style="list-style-type: none"> • identifying and addressing behaviors that may jeopardize housing (e.g., lease violations) • education and training on the role, rights, and responsibilities of the tenant and landlord • individualized case management and care coordination (e.g., connecting the individual with Medicaid and non-Medicaid service providers and resources)

Source: CMS 2021a.

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. Allowable 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 lead abatement activities (CMS 2017a).

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 are using them 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), has provided \$3.7 billion to 43 states and the District of Columbia to help Medicaid



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beneficiaries transition from institutions back to the community (HHS 2017). Until recently, eligibility was limited to Medicaid beneficiaries residing in an institution for 90 days or more, not counting short-term rehabilitation days.³ The Consolidated Appropriations Act of 2021 (P.L. 116-260) reduced the minimum stay requirement to 60 consecutive days in an institutional setting, which may include days admitted for short-term rehabilitative services. 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.

MFP states have also partnered with public housing authorities to provide housing choice vouchers to beneficiaries which can be used to secure housing within the community.⁴ More than 101,000 people with chronic conditions and disabilities transitioned from institutions back into the community through MFP programs between 2008 and 2019 (CMS 2021b). The program was set to expire at the end of 2018; however, Congress authorized new funding through fiscal year (FY) 2023.⁵ States can roll over unused funds for four subsequent fiscal years (§ 6071 of the DRA). Therefore, FY 2023 funds will be available for expenditures through FY 2027.

Section 1115 waiver demonstrations

Several states cover housing-related activities or services for Medicaid beneficiaries through demonstration waivers authorized under Section 1115 of the Social Security Act (the Act). 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. Some Section 1115 demonstrations, including those in Illinois and New Jersey, focus on addressing housing insecurity for high-cost, high-need beneficiaries, such as individuals with serious mental illness. Other demonstrations, including those in California and North Carolina, are broader efforts to address housing as well as other social determinants of health, such as nutrition, transportation, and interpersonal violence.

Under the Medi-Cal 2020 demonstration, 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. A majority of the 25 pilot programs offer such services 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. Services are delivered in coordination with managed care organizations, the public housing authority, and community-based organizations. Pilot programs may also connect beneficiaries to permanent housing opportunities through the use of a county-wide housing pool (Pagel et al. 2019).⁷ In Los Angeles County, which administers the largest pilot, 60 percent of program funding is targeted to individuals who are experiencing or at-risk of homelessness, many of whom have behavioral health conditions (HHS 2020, 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 services to help beneficiaries with disabilities, older adults needing LTSS, and those experiencing chronic homelessness 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. 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.⁹

Most states (46) operate at least one Section 1915(c) waiver to deliver housing-related services such as assistance transitioning into community-based living, home modifications, and one-time moving expenses (MACPAC 2020). 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.¹⁰ 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 have a need for housing and tenancy support to participate in Louisiana's supportive housing program.¹¹ 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).

Minnesota uses four different Section 1915(c) waivers to provide housing-related services, among other HCBS, to individuals with traumatic brain injuries, developmental and physical disabilities, and those with chronic illness. Waiver services and supports help Medicaid-eligible individuals transition into community living and include coverage for certain expenses related to moving, finding a home, developing 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 (MACPAC 2020, 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 HCBS, including housing supports, for individuals age 18 years and older who are eligible for Medicare and Medicaid, require either a hospital or nursing facility level of care, and reside in a participating county.¹² Covered services include non-recurring set-up expenses (e.g., furniture, food preparation items) for individuals who are transitioning from an institutional setting or another provider-operated living arrangement to a private residence (CMS 2019).

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

Section 1915(i) of 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 state plan 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 (CMS 2020a). Under Section 1915(i), North Dakota provides pre-tenancy and tenancy sustaining services to individuals who could be safely transitioned from an institutional setting to a lower level of care, individuals who are at risk of institutionalization, and those who are experiencing or at risk of homelessness (CMS 2020b).

Section 1905(a) state plan services

Section 1905(a) of the Act gives states the authority to provide services under the Medicaid state plan for individuals transitioning from institutions, or trying to obtain or maintain housing in the community. An example of such a service is 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)). Connecticut offers targeted case management to individuals with SUD 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 1945 health home state plan option

Section 1945 of the Act allows states to establish health homes to integrate physical and behavioral health and LTSS for individuals with certain chronic conditions. Among other service requirements, health homes must provide comprehensive transitional care from inpatient to other settings, as well as referrals to social services and supports. States receive enhanced federal matching funds for health home services for an initial period. As of December 2020, 21 states and the District of Columbia operated 37 health home models targeting beneficiaries with behavioral health conditions, HIV/AIDS, and other chronic conditions (CMS 2020c).¹³

A number of health homes provide housing resources for Medicaid beneficiaries (HHS 2020). For example, under Maine's health home for individuals with opioid use disorder, providers conduct a comprehensive clinical assessment upon intake, which includes assessing beneficiary needs related to housing. Health home providers also make referrals to address identified social service needs, including assistance accessing and maintaining safe and affordable housing (CMS 2017b).

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 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. States receive a 6-percentage point increase in federal matching payments for CFC state plan expenditures (CMS 2021).

Under CFC, states 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 to increase independence or substitute for human



assistance. As of FY 2018, eight states—California, Connecticut, Maryland, Montana, New York, Oregon, Texas, and Washington—were using Section 1915(k) state plan authority (Watts et al. 2020).

Health Services Initiatives

States can use some of their 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).¹⁴ HSIs must directly address the health of children eligible for Medicaid or CHIP but may serve children regardless of household income (CMS 2017a). States are also encouraged to use an approved HSI to enroll eligible but unenrolled children in Medicaid or CHIP.¹⁵

Generally, the HSIs approved by CMS have addressed services related to public health interventions and prevention, such as poison control and youth violence prevention (CMS 2017a). However, some states, including Michigan and Maryland, are using HSIs to address and reduce childhood lead poisoning, including through lead abatement activities.¹⁶ States seeking approval to implement such activities must meet certain criteria such as using state-certified individuals to perform abatement services that have been proven to be effective 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 the 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 are or were served by the Flint water supply between April 2014 and a date to be determined in the future.¹⁷ ¹⁸ To complement that demonstration, CMS approved an HSI authorizing \$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 FY 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 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 the 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 or 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 Whereas the 2015 CMS informational bulletin focused exclusively on housing, the 2021 CMS state health official letter on SDOH addresses housing-related services as well as non-medical transportation, home-delivered meals, educational services,



supported employment, community integration and social supports, and case management. The letter also outlines overarching requirements states must meet when providing services to address SDOH (CMS 2021, CMS 2015).

³ 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).

⁴ 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).

⁵ The MFP demonstration was most recently extended by the Consolidated Appropriations Act of 2021 (P.L. 116-260), which appropriated \$450 million in federal funding for each of FY 2021, FY 2022, and FY 2023.

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 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.

¹⁰ 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).

¹¹ Priority is given to individuals transitioning from institutions and homeless individuals or households (CSH 2017).

¹² 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).

¹³ California, Connecticut, Delaware, District of Columbia, Iowa, Kansas, Maine, Maryland, Michigan, Minnesota, Missouri, New Jersey, New Mexico, New York, Oklahoma, Rhode Island, South Dakota, Tennessee, Vermont, Washington, West Virginia, and Wisconsin operate Medicaid health homes under the state plan. Several states and the District of Columbia have multiple health homes to target specific populations, such as those with serious mental illness or HIV/AIDS (CMS 2020c).



¹⁴ 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 2017a).

¹⁵ 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 2017a). 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.

¹⁶ Lead poisoning has severe implications for 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 24 and 72 months with no record of a previous blood lead screening test must receive one. Separate CHIPs 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 2017a).

¹⁷ 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).

¹⁸ On December 21, 2020, CMS approved a temporary extension of Michigan's Section 1115 demonstration, which currently expires on February 28, 2022 (CMS 2020d).

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