

Advocating for Housing-Related Services in Your State's Medicaid Plans

States are expanding opportunities to deliver housing related services and other Health Related Social Needs (HRSNs) screenings and services. Affordable housing advocates should be aware of the basics of their state's processes, so that they can leverage these new services and potential coalitions to achieve their goals of more equitable communities, supportive housing at scale and greater opportunities for ALL community members to thrive.

NLIHC calculated the 2022 national housing wage at \$25.82 per hour, which is the wage needed to afford a modest two-bedroom home. Yet, the federal minimum wage remains \$7.25 an hour deficit of this amount at \$18.57 per hour leaving affordable housing out of reach for millions. Within this widespread affordable housing crisis, persons with disabilities are even more likely to be poor and to experience homelessness. According to *Priced Out*, there is nowhere in America where a person on Supplemental Security Income (SSI), the basic income program for persons with disabilities, can afford a decent place to live. SSI is the basic income program for persons with disabilities. Our country's history of structural and intuitional racism contributed to more Black, Indigenous and People of Color (BIPOC) being dependent upon this income than whites. As a result of these inequities, BIPOC are more likely to be homeless, suffer the effects of mass incarceration, and have poorer health. A growing body of literature highlights that BIPOC are more likely to live in nursing homes or congregate care settings and that often deliver lower quality of care.

Persons with disabilities can benefit from supportive housing, a program model that combines affordable housing and support services in order to assist low-income persons with disabilities. Supportive housing provides a chance for tenants to achieve affordable, stable housing to fully integrate into their

communities. A [2019 CSH Needs Assessment](#) estimates that creating an additional 1.1 million supportive housing units nationwide would address a variety of housing needs, including: homelessness, institutional placements, reentry from incarceration, and aging populations. Medicaid, as an entitlement program, is currently the only feasible program option for funding the supportive services needed to move beyond pilot programs and create supportive housing at scale.

The creation of new supportive housing generally requires three sources of funding:

1. The necessary capital to acquire land and build housing;
2. Operating subsidies to keep the housing affordable to persons with extremely low incomes; and
3. Services funding to assist persons with disabilities and other needs access, locate and maintain housing.

Notably, programs that use community landlords, commonly called scattered-site programs would not need capital funding, if a local landlord network will accept operating subsidies and agree to participate in a supportive housing program.

Creating or Adapting Your State's Medicaid Housing Related Services (HRS) Benefit

For many communities, services funding can be the most challenging to access and braid with the other funding streams to create new supportive housing. In many states, advocates and state officials have worked together to leverage a state's Medicaid program to offer Housing Related Services (HRS). HRS commonly includes pre- and post-tenancy services. **Pre-tenancy services** helps people find eligible housing and **post-tenancy services** help people maintain housing over time. Medicaid programs in at least [20 states](#) now offer some type of HRS as part of the

state Medicaid plan. For example, Massachusetts and Louisiana have been using their state's Medicaid plan for this purpose for close to two decades. The Centers for Medicare and Medicaid Services (CMS) offered guidance in 2021, noting that states can choose whether or not to offer this service.

Once a state elects to offer the service, your state Medicaid office has important decisions to make, which advocates can influence. These choices will determine **IF** this benefit can assist in the creation of new supportive housing for Medicaid beneficiaries. These decisions include:

- Determining benefit eligibility and how that eligibility is proven to the state.
- Defining eligibility broadly or narrowly: a broad definition could allow eligibility for persons with at least one chronic health condition, or a narrow definition could establish a certain risk score.
- Simplifying the administrative process for Medicaid beneficiaries in how they prove their eligibility or states can making the process administratively burdensome so that fewer people qualify.
- Deciding which services to offer, such as pre-tenancy, post-tenancy, housing deposits, community transition, or home modification services.
- Choosing to offer the benefit via a Third-Party Administrator who is tasked with bringing in housing related providers to the network of services providers OR states can offer via their Managed Care Organizations (MCOs). Although the latter creates administrative burden for housing related agencies who would then need to contract with and bill the many MCOs that may cover their residents.

Advocates also play a role in ensuring that state choices are guided by principles of equity and inclusion. They can advocate for a program that serves as many people as possible while creating simple, accessible systems of access. Affordable housing and homeless services providers should also ensure that there is a clear pathway to

reimbursement of their services.

Medicaid benefit programs often evolve in important details over time. States typically develop amendments to services, as persons served, providers, advocates, and family members provide feedback on which aspects of the program are working and which aspects are not. Advocates should know there is always the potential for change in the program. As an entitlement service, if the new services are offered via a State Plan Amendment (SPA) Medicaid authority, the state is required to deliver services TO ALL who meet the criteria and can prove that eligibility to the state or state contractors. State or Managed Care rates for providers may also change over time, if providers can provide documentation that proves the cost of delivering care exceeds the rate of reimbursement. State may choose to pay providers through one of the three most common payment mechanisms:

- 15-minute increments.
- Per diem (a daily rate).
- Per Member, Per Month (PMPM).

Out of these methods, PMPM rates provide the lowest administrative burden for providers. On the other hand, 15-minute increment payments are the most burdensome for direct care workers and agencies to document and bill.

Align the Benefit with Affordable Housing in Your Community at the Systems Level

HRS will only create new supportive housing if persons in need can access these services AND the affordable housing needed to create supportive housing. Structural connections need to be in place at the systems level between these new HRS and the affordable housing options in communities. Since approximately only 1 in 4 persons who qualify for housing assistance receive that assistance, communities will have to develop cross sector referral systems between these new housing related services and affordable housing opportunities in communities. New waivers in Arizona, California, and Oregon can offer short-term housing options of either

Medical Respite (called Recuperative Care by Medicaid) or six months of housing assistance. These programs can be bridges to long-term affordable housing opportunities in communities, but only **if** that affordable housing exists and is linked systemically to these Medicaid-funded housing options. Aligning these systems should occur at the government or system level, with a goal to ensure equitable access. To align housing and services, communities need to establish a **cross-sector referral system** between housing and services. Equity needs to be centered in the process of creating such a referral system. In an ideal, equitable system, individuals are referred to housing options in a community, including short-term housing options. There should be no gap between these shorter-term settings and when individuals enter permanent, affordable housing options.

For systems to come together to create a cross-sector referral system, both sectors need to be aligned on serving the same population with similar goals. If the housing sector is prioritizing persons experiencing chronic homelessness or those over age 65, who is the health sector prioritizing? Data matching between systems can help determine a priority population and create a list of people who meet all eligibility criteria and can be engaged for these housing opportunities. Without alignment on populations served, a state or community risks leaving groups without services and serving no one effectively.

NEXT STEPS FOR ADVOCATES

Learn: Where is my State Medicaid plan, regarding covering Housing Related Services (HRS)?

Use the CSH interactive [map](#) to determine if your state offers these services and to whom? If your state does not offer these services, advocate to have these services covered by your state's Medicaid plan. Likewise, get involved and raise issues with your state legislators or Medicaid offices around populations served, linkages to long-term affordable housing, and how your state can make Medicaid enrollment simpler and easier. Organize housing and homeless services

providers around the challenges that make it difficult to operate efficiently, and advocate to eliminate or reduce those barriers. If your state is not a Medicaid expansion state, support and join the state coalition working on that issue.

Network

Who are the healthcare partners that are implementing Health Related Social Needs (HRSN) programs? What are they learning and finding about those needs in your communities? How are they addressing those needs and resource gaps? Are they authentic partners with community members and social services organizations that are already on the ground and addressing those needs? As a growing number of health care partners recognize the need for affordable housing, you have an opportunity to build a network and coalition of new healthcare partners.

Research

If your state has a HRS benefit, who is accessing the benefit and is access equitable? If not, what changes would be needed to make access to the benefit equitable? Is the benefit reducing health costs and helping people thrive in communities? If so, tell that story! What reports do your state already have about the benefit that need to be promoted in order to gain broader support or effect change? Does your benefit have significant administrative barriers that hinder progress? How can those barriers be eliminated or reduced?

Organize

If your state does not have a benefit, organize those who would benefit to tell their story about why expanding access to supportive housing is so important to your community. If your state does have a benefit but the benefit is inaccessible, communicate the impact this fact has on community members. If your state is doing well, tell that story to demonstrate impact and maintain support for the program.

Conclusion

Medicaid for supportive services is the best option for moving beyond pilots and creating enough supportive housing for all. As more

healthcare providers are screening for Health-Related Social Needs (HRSNs) and moving towards a better understanding of the resource gaps in our communities, affordable housing advocates can find powerful new partners in their work. Equity and the voices of people with lived expertise (PLE) of institutionalization and housing instability must be centered in these evolving efforts. This advocacy work is essential to ensure full community integration, end homelessness and make sure that everyone in need has equitable access to supportive housing in communities of their choice.