Housing and Services
Resource Center

Medicaid Delivery Systems for Housing Partners

Introduction

Housing and homeless assistance agencies seeking services funding for their residents and participants have new opportunities in many states that are using their Medicaid programs to provide Housing-Related Services and Supports (HRSS). Designed to help people access and maintain safe, stable housing, these services can include (but are not limited to): housing navigation (help finding and securing housing), transition and moving costs (e.g. security deposits and housing application fees), and tenancy-sustaining case management.[1] For persons who are experiencing homelessness and housing instability, these services are critical to achieving positive health outcomes. Housing and homeless assistance agencies may be currently delivering many services that are eligible for Medicaid HRSS funding in their shelter, transitional housing, rapid rehousing, and permanent supportive housing (PSH) programs. However, being able to receive reimbursement for these services requires specialized knowledge, capacity, and/or partnerships that few agencies funded primarily by Department of Housing and Urban Development (HUD) grants have. Medicaid operations vary considerably from state to state, and the Medicaid community commonly uses the term “delivery systems” to describe how the Medicaid program is operated in any given state. This brief will:

- Help Continuums of Care and housing and homeless assistance agencies understand various Medicaid delivery system models.
- Highlight key partners in the health space, including Community Care Hubs, Aging and Disability Networks, and Home and Community Based Services, and the importance of cross-system partnerships.
- Share examples of states utilizing various delivery system models.
- Highlight next steps that Continuums of Care (CoCs) and housing and homeless assistance system providers can take to learn where their state is in this process and how to get involved, if they are in a state that has opted to cover these services.

Delivery Systems

Introduction to Delivery Systems

Medicaid is a federal and state partnership, and states have flexibility in the administration of their programs within broad federal guidelines, such as the option to cover Housing-Related Supports and Services. The Medicaid State Plan is the state contract with the Centers for

[1] For more information on HRSS, see: Medicaid-Funded Housing Services.

Medicaid and Medicare Services (CMS) to administer the program. Each Medicaid State Plan is publicly available and outlines the services covered in your state and the populations who are covered.[2] Each state must decide on the delivery system(s) they will use to ensure that all Medicaid recipients can access the services to which they are entitled. A "delivery system" is defined as how and with whom the state contracts within order to ensure that their Medicaid members can access high-quality healthcare, including all state-covered services. The three most common delivery system models are:

1. Fee For Service: Providers bill the state at a rate for services that is standard statewide.
2. Managed Care: The state contracts with a Managed Care Plan (MCP) to develop and manage a network of high-quality providers. Most MCPs operate on a capitated rate arrangement where they are paid a monthly rate per person and expected to manage funds to stay within the budget. States may choose to have MCPs operate statewide, by region, or by county.
3. Third Party Administrator: The state has contracted with a single MCP to manage a particular benefit such as Housing-Related Services and Supports (HRSS) or a particular population such as child welfare involved youth or those persons who are enrolled in both Medicaid AND Medicare.

State Medicaid programs typically consider the people they serve to be in different populations. Typical populations include the "Aged, Blind and Disabled" or those on Supplemental Security Income (SSI)/ Social Security Disability Income (SSDI), children, pregnant and parenting people, and the Medicaid expansion population, who meet the criteria for low income but do not fit other categories such as disability, pregnancy, or age (young or old). States may use different delivery systems for different populations.

Fee for Service (FFS)

Fee for Service (FFS) refers to a state choice to cover some Medicaid subpopulations under a state only system and not use an outside contractor such as a managed care plan. A few populations such as Tribal Members or persons with intellectual disabilities living in an institution are federally required to be covered by the state's FFS system. Tribal members can choose to opt into Managed Care but cannot be required to use a managed care system. States choose which populations to include in managed care and which to operate outside of the managed care systems. As of the end of 2024, there are nine states (AL, AK, CT, ID, ME, MT, SD, VT, WY) using primarily a Fee for Service delivery system.

If your state or population is covered under FFS, the state Medicaid plan lists what services are covered for which populations and publishes a fee schedule that outlines what fees will be paid for what services. Providers generally input data directly into the state's Medicaid Management Information System (MMIS) and are paid on those claims.

State may use unique terms to highlight who is covered by the state Fee for Services systems. In Oregon these are Oregon Health Plan Open Card Members. North Dakota covers all

[2] To find out more about the Medicaid program in your state, see: State Profiles | Medicaid

populations except the expansion populations via the state FFS and calls them "Traditional Medicaid". States such as Hawai'i, Iowa, Michigan, Nebraska, New Hampshire, New Jersey, Pennsylvania, Tennessee, and Virginia have at least 90% of their Medicaid population covered by managed care, and therefore few people in the state's FFS program.

Managed Care

41 states use managed care as their primary delivery system to develop provider networks to deliver Medicaid covered services.[3] States contract with these entities on an annual basis and commonly release a Request for Proposals (RFP) every 3-5 years to re-procure their Managed Care Plans (MCPs). MCPs may also be called Managed Care Organizations (MCOs), Managed Care Entities (MCEs) or Health Plans, but for the purpose of this brief, we will use MCPs. States may choose to use a variety of managed care models to cover their Medicaid population. The most common is the risk-based capitation model, in which the state contracts with more than one managed care plan (MCP) and pays a pre-determined amount Per Member, Per Month (PMPM) to the MCPs, who are expected to manage health care costs to who are expected to manage health care costs to stay within their budgets.[4] Rates are determined by prior uses of health care by a geography or population and are required to be actuarially sound. MCPs determine what they pay providers for what services based upon their budgets.

States decide what services are "Carved In" or "Carved Out" of managed care. Carved in services are what the health plan covers, such as primary care, specialty care, behavioral health care, pharmacy benefits or Long-Term Care (LTC). States may determine that other services are carved out, meaning the services remain in the FFS system described above, and the state pays directly for these services using a fee schedule.

Agencies providing Medicaid services for the first time will need to know how your state operates the program in order to know who to contract with to deliver and be paid for services. States can choose to have their managed care system operate statewide (e.g. DE, IN, NJ, RI), by region (e.g. FL, MN, PA, TX, WA), or by county (e.g. CA, OR). Statewide means a group of plans operate statewide to cover Medicaid members. Regionally means a certain region of the state is covered by the state plans, and county plans means each county has its own MCPs.

Third Party Administrator (TPA)

Arizona and Washington are both using a Third-Party Administrator model to operate their HRSS programs. Rather than using multiple MCPs in a single geography, the state has contracted with one organization to manage the benefit and ensure an adequate provider network to deliver services. In Washington, the state has chosen Wellpoint as the TPA to administer the benefit. The state and Wellpoint require that providers submit compliant Medicaid claims for payment. Arizona has chosen Solari to operate the Housing and Health Opportunities (H2O) program. H2O is the state's 1115 waiver coverage of pre and post tenancy services and short-term rental assistance. Providers operating these services in Arizona are not required to

[3] Total Medicaid MCOs | KFF
[4] Capitation and Pre-payment | CMS

submit Medicaid claims; rather the state is requiring that Solari accept invoices for payments and then transform them into Medicaid-compliant claims.

Introduction to Other Critical Partners

Each state operates a unique health care ecosystem that can include managed care or other administrative models as well as provider networks, including those for Home and Community Based Services, Aging and Disability networks, and other partners. Area Agencies on Aging (AAAs or Triple As) offer services to aging community members who need assistance with social and in-home support to remain at home. Aging and Disability Resource Networks (ADRCs) and Centers for Independent Living (CILs) offer assistance to qualified persons to remain in the community and live as independently as possible. Cross-sector partnerships between these entities and the housing and homeless system are critical, as all are resource constrained yet serve a common population who is experiencing multiple barriers (fixed income, disability, lack of accessible and affordable housing) to full community living. Bringing these providers and networks together with housing and homeless assistance providers in cross-sector partnerships and building their capacity is critical to ensuring the successful implementation of high-quality housing-related supports and services funded through Medicaid. One important note is that the geography for each of the key partners may differ. For example, the geography covered by your Continuum of Care may be served by multiple Managed Care Providers and one or more AAAs, ADRCs, and/or CILs.

The Challenge of Medicaid Claims and a Solution- Community Care Hubs

Being a part of Medicaid delivery systems commonly requires cross-sector partnerships and an infrastructure that is beyond the capacity of many small agencies. Cross-sector partnerships commonly require a backbone organization that supports the partnership, develops and maintains the vision, supports infrastructure and brings together multiple agencies in a way that is beneficial to all. As described above, in most cases, to participate in HRSS programs, housing and homeless assistance providers will need to be able to create a submit a Medicaid claim, a process that requires significant infrastructure investment to begin. Your community likely also has other HCBS providers for whom this is a challenge as well.

The federal government, via the Administration for Community Living, has supported the development of Community Care Hubs, which operate as a backbone organization and offer needed infrastructure to agencies. Community Care Hubs have or are developing capacity to assist Community Based Organizations (CBOs) to connect to the state's Medicaid program for services funding.

Next Steps for CoCs and Housing and Homeless Assistance Providers

State Context

- Learn if your state covers these services and if so, via what delivery system. Search for information on your state's Medicaid Agency here: Where Can People Get Help With Medicaid & CHIP? | Medicaid. In addition, the Policy Brief: Summary of State Actions on Medicaid & Housing Services and Medicaid and Housing Related Services Toolkit are two resources updated regularly with key information to help CoCs and housing and homeless assistance leaders learn about their state's policy and implementation efforts on HRSS. Be aware that the process from state Medicaid approval of services to implementation of services can take from 1-3 years. States use the term "GO LIVE" to mean when agencies can begin to bill for newly approved services.
- If your state does not cover HRSS, engage state and local leaders on the need for coverage of these critical services. To learn more about some of the states with approved plans covering HRSS that can serve as examples and inspiration for your discussions, see: 2024 Housing and Services Partnership Accelerator (HSPA) | ACL Administration for Community Living.
- It is important to keep in mind that wherever your state is regarding this process, the program is evolving and can be improved upon. Consider joining an existing coalition or developing a coalition of agencies that are implementing the program and work together to make recommendations for improvement. States make changes regularly regarding payment rates, services, covered, who is eligible for services, access processes, and quality metrics.

Partnerships

- Identify critical new partners to move the work forward and engage. Learn what your agency or network's strengths and weaknesses are and gather new partners who are strong where you have gaps in knowledge and capacity.
- Bring together potential partners including Aging and Disability Resource Networks and any local Community Care Hubs[5] to move the work in your community forward. Analyze partners, strengths and challenges and recruit new partners to address challenges, such as working with partners with Medicaid billing capabilities.
- If your state does not cover Housing-Related Supports and Services, get involved or start a conversation in your state about this critical benefit.

Data

- Track who your agency or your CoC is serving and information about their health care coverage. CoCs can create templates and tools to track this data or integrate this information into an existing Homelessness Management Information System (HMIS).

[5] Advancing Partnerships to Align Health Care and Human Services | ACL Administration for Community Living

- Consider what information you have access to that can be shared to inform partners and enhance access to critical services for those experiencing homelessness in your community. For example, point in time counts, Longitudinal Systems Analysis data (and particularly the visuals of this data available through Stella), results of system mapping and modeling exercises, and more can help health partners understand the housing needs in your community and how their services may be able to fill gaps.
- Reach out to the appropriate agency with your information. This may be a Managed Care Plan or Third Party Administrator, an Aging or Disability network, or the state
- Determine what referral and/or billing platforms exist in your community. Can any of them assist with your efforts?

Training

- Learn about your local delivery system and train other partners and agencies on what you learn. Teach new health partners about your coordinated entry processes, your Homelessness Management Information System (HMIS) and other key information about your systems.

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