Housing and Services
Resource Center

Working with Managed Care Plans to Implement Housing-Related Supports and Services

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). These interventions are designed to help people access and maintain safe, stable housing, and 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. For persons who are experiencing homelessness and housing instability, these services are critical to achieving positive health outcomes.

Housing and homeless assistance agencies seeking to utilize HRSS funding (in states that cover these services through Medicaid) must learn to work within the delivery system that their state uses to operate Medicaid programs. The most common is the managed care delivery system, in which the state contracts on an annual basis with Managed Care Plans (MCPs).[1] The contract requires that MCPs operate a provider network of agencies that can offer all the direct care services included in the state Medicaid plan. MCPs are required to have an adequate and quality provider network that ensures that members can access care in a timely manner.[2] For MCPs that need to build their existing network of agencies to include those that can operate HRSS programs, tapping into the housing and homeless assistance sector is crucial. The experience and expertise that housing and homeless assistance have in providing the types of services covered under HRSS, and the access they have to long-term housing options for Medicaid members make them ideal partners for MCPs. Learning to work with MCPs, however, poses challenges, as housing and homeless assistance providers need to learn, plan for, and execute administrative activities that may be unfamiliar to them.

This brief will:

- Highlight some of the key steps that housing and homeless assistance agencies should be prepared to take if their state has made the decision to offer HRSS via a managed care delivery system

[1] Total Medicaid MCOs | KFF
[2] Ensuring Access to Medicaid Services Final Rule (CMS-2442-F) | CMS

- Highlight some strategies that housing and homeless assistance agencies and their managed care and state Medicaid partners can take to address challenges that have arisen in states as these agencies have worked to join managed care provider networks
- Highlight how states can work (or are already working) to ensure that housing and homeless assistance providers can become part of managed care networks to offer HRSS.

New Efforts Needed by Housing and Homeless Assistance Agencies

One of the most significant challenges faced by states implementing HRSS via a Medicaid delivery system is the difficulty in helping housing and homeless services that are new to Medicaid managed care make the changes needed to operate in a Medicaid environment. The road to being able to be paid by a state's Medicaid program or delivery system is a multi-step administrative process. Understanding the various steps that will need to happen before Medicaid billing can begin (and the sequence of these steps) can help providers get a sense of what they are in for and how to prepare. Although the process will look a bit different in every state, in general providers should be prepared to undertake the following steps:

1. Agencies will need to track health care or insurance coverage for the people they serve, to see who they could provide with HRSS via Medicaid funding. Commonly, until an agency is an enrolled Medicaid provider they will not have access to this information and must rely on self-reported data regarding coverage.
2. Agencies then will need to obtain a National Provider Identifier (NPI), an identification number issued by the Centers for Medicare & Medicaid Services (CMS). California has created a step-by-step guide on the NPI application process for their new Medicaid providers offering Enhanced Care Management & Community Supports services. Since NPI is national, most of the guide will be applicable to any state.
3. In most states, agencies will need to contract with the state as a state Medicaid provider. The process usually includes a provider agreement, signed by the agencies that housing and homeless assistance agencies will need to review closely to be sure that they can comply with all requirements. Agency workflows, data systems, training requirements and other operations may need to be modified to come into compliance with the provider agreement or MCP contract option.
4. Once that agreement is signed, agencies commonly receive a letter from the state that includes their agency's Medicaid number that is needed in all submitted invoices or claims. At this point, with the letter in hand, agencies can now approach their local MCPs for contracting opportunities. Agencies can now also access the state's enrollment system to check with the system to ensure that those they serve are Medicaid enrolled participants.
5. Once participant enrollment in Medicaid is confirmed, an agency must learn and follow the process for approval of an individual for the state's HRSS program. MCPs may require assessments or authorizations before services that are delivered can be paid for via Medicaid.

Cross-Sector Partnerships

Going through all of the steps outlined above and taking on other issues related to transitioning to a Medicaid managed care environment can be extremely challenging. New administrative models such as Community Care Hubs, which provide infrastructure to help community-based organizations to contract with healthcare organizations, can support agencies by centralizing administrative efforts such as billing.[3] In addition, other cross-sector partnerships work can help housing and homeless providers work with new partners to address challenges with the startup and implementation of HRSS through managed care delivery systems.

- The Cross-Sector Partnerships Roadmap can help guide efforts to bring together partners, define community needs, and create shared goals. State Interagency Councils on Homelessness (ICHs) can be a table where strategic partners come together to create the needed policy goals and support. Subgroups of such councils may tackle cross-sector challenges and include middle managers at essential state departments.
- At the provider agency level, consider ways to create coalitions of agencies who are on the Medicaid journey together and can support each other's efforts. These groups can be effective in helping identify common challenges they are facing and communicate these in a collective manner to the state or MCPs. Community Care Hubs can also be the convenor for such a group and offer the backbone support that cross-sector efforts need to be effective.[4]
- When sectors come together, one of the key first steps is to map the access process. How does a person access HRSS in your community? How can someone get connected with the local Coordinated Entry process for access to housing and services, or access other affordable housing opportunities? How can someone get enrolled with Medicaid? Educating all sectors on the access process for their resources will help partners understand where these sectors need to come together. A Person-Centered Design process to integrate systems may be needed to reduce complexities and reach the populations who most need the services and housing assistance.

Cross-Systems Data Work

Another challenge faced by communities implementing HRSS through a Medicaid delivery system is the need to navigate multiple data systems and languages. Each sector has its own data standards and requirements, such as the housing and homeless assistance sector's Homeless Management Information System (HMIS), and partners new to working together typically do not have an understanding of or access to each other's systems. The same data element can have different names and definitions in different systems. Steps that can be taken to support work to address cross-systems data challenges include:

- Identifying which kinds of data systems and elements are required by the different funding sources for partners at the table and create interoperability strategies. For

[3] For more on CCHs, see: CCH-Primer-Final.pdf

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

example, some states are developing Social Drivers of Health Platforms with new billing capabilities.

- To identify potential for interoperability between systems, start by mapping the relevant systems and each systems' data standards, data definitions, and the potential for interoperability between systems.
- Work through areas when similar terms may mean different things across sectors and data systems. For example, California created CalAIM Data Sharing Authorization Guidance to educate multiple systems on federal and state laws around data sharing in the health arena and began to define cross-sector compliance with these laws.
- Explore data solutions that work for partners in multiple sectors. For example, States are increasingly adopting Closed Loop Referral Systems (CLRS) to allow the health care sector to make and track referrals for a variety of services patients need that are not provided by health care.[5] Emergency, transitional and permanent housing options are just a few of the services these systems aspire to track. These systems are also developing capacity to submit invoices and claims for services to the appropriate payer, increasing their utility to CBOs. These systems include the developing potential for a single-use system for provider agencies for all their data needs. The housing and homeless assistance sector will hear much more about these platforms in the coming years.

Role of the State - Capacity-Building for Housing and Homeless Assistance Agencies who are New to Medicaid Operations

States can help housing and homeless assistance providers making the transition to a Medicaid managed care environment by providing a variety of capacity-building funds and technical assistance support. States that have an approved Health Related Social Needs 1115 waiver may already have these funding sources and technical assistance support or may be developing them. For example, technical assistance may be provided to train agency staff on the Medicaid processes including provider enrollment, confirming participant eligibility, developing budgets and cash flow projections, and billing and documentation efforts. Agencies may also fundraise to meet their capacity-building needs, and philanthropy is often well-positioned to support agencies in the short term as they make a transition to a sustainable long-term funding source, such as using Medicaid for services.

Capacity building funds are needed for the start-up phase, as agencies will have costs prior to being able to bill Medicaid for services, such as revising workflows, developing new data systems, hiring new staff and other efforts. In addition, Medicaid is a retrospective payment system (deliver services, then get paid) rather than a prospective one (get paid, then deliver services). Although some agencies may be used to working in such a payment environment and have the resources to cover expenses long enough to get reimbursed, others that are used to operating in a grant-funded or other prospective payment structure will need support building

[5] Community-Resource-Referral-Platforms-Guide.pdf

their capacity to adapt to retrospective payments. HRSN waivers for capacity-building funds have been allowed for four categories of expenditure:

1. Technology
2. Workforce
3. Business Operations
4. Outreach and Engagement

Agencies may also choose not to build a Medicaid billing infrastructure and might want to outsource this aspect of their operations. In this instance, a Community Care Hub (CCH) might be a strong new partner to support these efforts. One may already exist in your community or local health care partners that are already billing may want to create one to address community needs. An infrastructure partner such as a CCH would make the transition less expensive and less onerous for small but critical community providers.

Role of the Continuum of Care

Continuums of Care (CoCs) have a critical role to play in helping their community roll out HRSS through a managed care delivery system and navigate challenges that arise. Major areas where the CoC Collaborative Applicant and CoC Membership can support homeless assistance agencies include:

- CoCs can learn about state opportunities for funding and capacity-building and share them with their network of agencies.
- CoCs can be organizing partners for a Community Care Hub or for meeting with MCPs or other organizations in the health care space.
- CoCs can organize trainings and community conversations about the potential of this new opportunity, helping their members and the public understand who is eligible for new HRSS services in the community, which agencies are providing them, and how they can be accessed.
- As data systems are adapted, CoCs will be charged with oversight to be sure that these changes do not interfere with HMIS data standards and other HUD requirements.
- CoCs can leverage their data to make the case for including housing and homeless response agencies in capacity-building opportunities.

Implementation Challenges and Solutions

Many of the Housing and Services Partnership Accelerator states are using managed care as their primary delivery system for new HRSS programs. The case studies below highlight some of the challenges and opportunities that CoCs and housing and homeless response agencies may face as these programs start up and operate in their states.

Hawai‘i - Listening to New Stakeholders in Medicaid

Hawai‘i has a long-standing and well-developed managed care delivery system, so when Housing Related Supports and Services began in their state in 2017, the state looked to their

managed care Health Plans to administer the program. The state had strong priorities around addressing homelessness and linking Medicaid beneficiaries to long-term housing solutions, including Permanent Supportive Housing (PSH). Health plans, however, did not have access to the Homeless Management Information System (HMIS) or relationships with Continuums of Care (CoCs) or homeless assistance providers, which made service delivery and care coordination challenging. The road to PSH was also hampered by the severe affordable housing crisis in Hawai'i, which meant that more and more health plan members were likely falling into homelessness and housing instability.

As a rapid cycle evaluation by the University of Hawai'i was incorporated into the program, Hawai'i was able to analyze data on the uptake of new services and found that the numbers were much smaller than expected given the amount of homelessness seen in their communities. To support implementation efforts, the state initiated bi-weekly meetings with health plans and providers to troubleshoot issues arising across health plans, providers and islands. This approach allowed the state to include critical stakeholders in the conversations, including CoCs and HRSS providers who operated in the housing and homeless assistance sector.

The state and the managed care plans also engaged in targeted capacity building that was data-informed and guided by the community and internal stakeholders. The state released a series of memos in 2023 clarifying and simplifying administrative requirements associated with the program. The first focused on a revised payment methodology that was task-based and followed a Per Member, Per Month payment mechanism. The team used two codes for screening and engagement services and another for tenancy and pre-tenancy supports. The initial assessment was pared back significantly because feedback noted that many people could not sit through the extensive initial assessment. The state team has released two additional memos noting simplified administrative requirements, based upon feedback from a range of partners throughout the community.

As of Fall 2024, the state has continued monthly meetings about the program that involve health plans, providers, and other stakeholders. The agendas for those meetings include space for 'walk on topics' as issues arise. The program has served over 1,000 unique members to date and enrolled about 80% of the state's homeless assistance providers. The journey around HRSS delivery and making changes when needed have allowed the state to establish deeper partnerships and improve implementation of HRSS.

California- Increasing Standardization Across MCPs

The California Department of Health Care Services adoption of programs addressing health-related social needs (HRSN), initially began in 2016 with the state's Whole Person Care (WPC) and Health Homes Program (HHP) pilots under the "Medi-Cal 2020 Section 1115 Waiver. The WPC Pilot was designed to test local initiatives to coordinate the physical health, behavioral health, and social services for Medi-Cal members ("members") who were high utilizers of multiple health care systems and, with the care coordination interventions and access to certain social services afforded under the pilot,

could reap improved health outcomes. Similarly, HHP pilot served eligible members with complex medical needs and chronic conditions who may benefit from enhanced care management and coordination. The promising results of the WPC and HHP pilots led to the design of particular initiatives under the California Advancing and Innovating Medi-Cal (CalAIM) waivers first authorized in December 2021. CalAIM is a framework that encompasses broad-based delivery system, program, and payment reform across the Medi-Cal program. CalAIM seeks to drive a population health approach; prioritizing equity, prevention, and a person-centered approach, while addressing social drivers of health. Federal authority was granted through the CalAIM Section 1115 demonstration and CalAIM Section 1915(b) waivers.

Two pillar initiatives under CalAIM which seek to address the health-related social needs of individuals facing or at risk for homelessness are Enhanced Care Management and Community Supports, both of which are implemented through California's Medi-Cal managed care delivery systems.

- **Enhanced Care Management (ECM):** ECM launched in phases, beginning January 1, 2022, as a new statewide Medi-Cal benefit available to eligible Medi-Cal managed care members. It is intended to provide intensive coordination of clinical and non-clinical, health-related social services needs for members having complex needs involving physical, behavioral, and social interventions. ECM provides a "Lead care manager" to members who are to meet members where they are—on the street, in a shelter, in their doctor's office, or at home. Through Enhanced Care Management, members can also be connected to Community Supports. The phased in approach for ECM began with the "Populations of Focus" for: Adults and their Families Experiencing Homelessness; Adults at Risk for Avoidable Hospital or ED Utilization and Adults with Serious Mental Health and/or SUD Needs. For detailed information, please refer to the Enhanced Care Management Policy Guide available at DHCS' web site: https://www.dhcs.ca.gov/CalAIM/ECM/Pages/Resources.aspx.

- **Community Supports:** Community Supports are services available in the Medi-Cal managed care delivery system. Medi-Cal Managed Care Plans (MCPs) are encouraged to offer Community Support services as contractually covered benefits to their members but are not required to do so. There are currently 14 Community Support services, 12 of which are approved under the 1915(b) waiver authority and 2 of which are approved under the 1115 Demonstration waiver authority. There are three Community Support services, covered under the 1915(b) waiver (often referred to as the "Housing Trio"): Housing Transition Navigation Services; Housing Deposits; and Housing Tenancy and Sustaining Services which are designed to support in members who are experiencing or at

risk for homelessness. In addition, the 2 Community Support Services—Short-Term Post-Hospitalization Housing, and Recuperative Care (Medical Respite)—have a room and board component and are intended to provide transitional housing and wrap around services for individuals needing a safe environment to continue recovery from an illness or hospitalization/skilled nursing facility stay. See the Community Supports Policy Guide available {same link to landing page as above] for more details. Beginning in July 2025, under recent federal approval of BH-CONNECT waiver, DHCS will make available a new Community Support: Six months of transitional rent may be available for Medi-Cal members transitioning from institutional settings or homelessness. While the service will be an optional Community Support offered through the Medi-Cal managed care delivery system beginning in July 2025; it will become a mandatory benefit beginning on January 1, 2026, for behavioral health populations for focus. DHCS is currently undertaking policy design for the new services with details forthcoming. For more detailed information, please refer to the Community Supports Policy Guide available at DHCS' website: Community Supports Policy Guide.

At the launch of both ECM and Community Supports, MCPs had a great deal of flexibility in administration. Particularly for Community Supports, because MCPs had the option of offering a menu of the 14 Community Support services, DHCS afforded MCPs flexibility in the service definitions. Many MCPs adopting different strategies for implementation, including variations in the suite of services that could be offered under specific Community Support services (e.g., goods and supplies covered under Housing Deposits), MCP-specific eligibility criteria for Community Supports, as well as utilization management and authorization processes. The lack of standardization, over time, proved challenging for contracted Community Support providers including community-based organizations, such as valued homeless services and housing providers.

To strengthen implementation and streamline administrative complexity, DHCS has taken a continual improvement process which engages and obtains feedback from MCPs, providers, including CBOs directly serving Medi-Cal members, County partners and other stakeholders. Feedback loops have led DHCS to identify areas where standardization is feasible and most effective for continued success of the Community Supports initiative. These are captured in DHCS Enhanced Care Management and Community Supports Action Plan which was recently updated in December 2024. Actions undertaken in 2023, for example, include removal of flexibilities permitted to MCPs to limit Community Supports services that deviate from DHCS' service definitions outlined in the Community Supports Policy Guide. This included ensuring MCPs adhere to eligibility criteria for members experiencing or at risk for homelessness, which were outlined in the Policy Guide to align with HUD definitions. Reports back from the field state that this standardization has helped providers, especially those contracting with

multiple MCPs, authorize services more readily. Standardization for authorization processes for ECM has also helped ECM providers streamline ECM member enrollment. This is especially important for members who are unsheltered and who need the intensive outreach and coordination to connect them to health care services and connect them to housing navigation services—and ultimately housing—as it becomes available. DHCS continues to actively engage and solicit feedback from partners and stakeholders to optimize the delivery of services and optimize Medi-Cal resources so that they are a valuable part of the overall homeless response system in local areas.

Conclusion

Housing and homeless assistance providers and state Medicaid offices and MCPs are beginning to work together to solve common, complex challenges in communities. Each sector has much to learn and much to teach. HPSA states with active Medicaid HRSS programs are at the forefront of addressing these challenges and bear watching in the future for the developing innovations to address cross-sector challenges.

This material is based upon work supported by funding under an award with the U.S. Department of Housing and Urban Development. The substance and findings of the work are dedicated to the public. Neither the United States Government, nor any of its employees, makes any warranty, express or implied, or assumes any legal liability or responsibility for the accuracy, completeness, or usefulness of any information, apparatus, product, or process disclosed, or represents that its use would not infringe privately-owned rights. Reference herein to any specific commercial product, process, or service by trade name, trademark, manufacturer, or otherwise does not necessarily constitute or imply its endorsement, recommendation, or favoring by the U.S. Government or any agency thereof. Opinions expressed in this document are those of the authors and do not necessarily reflect the official position of, or a position that is endorsed by, HUD or by any HUD program.