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POLICY SERIES

Housing Is Mental Health Care: A Call for Medicaid Demonstration Waivers Covering Housing

Jennifer Mathis, J.D.

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Dear Reader,

Now is the time to solve the growing behavioral health needs in our country by advancing public policies that transform the delivery of mental health and substance use disorder services and address outdated funding mechanisms.

This paper is part of Think Bigger Do Good, a series of papers launched in 2017 through the support and leadership of the Thomas Scattergood Behavioral Health Foundation and Peg's Foundation. While the paper topics continue to evolve, our goal to develop a policy agenda to improve health outcomes for all remains constant.

In partnership with national experts in behavioral health, including our editors, Howard Goldman and Constance Gartner, we identified seven critical topics for this third series of papers. Each paper identifies the problem and provides clear, actionable solutions.

We hope you join us in advocating for stronger behavioral health policies by sharing this paper with your programmatic partners, local, state, and federal decision makers, advocacy organizations, and voters. To learn more about Think Bigger Do Good and to access the other papers in the series, visit **www.thinkbiggerdogood.org**

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Housing Is Mental Health Care: A Call for Medicaid Demonstration Waivers Covering Housing

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1 / Introduction

Housing is a basic human need and a key social determinant of health. As state mental health systems have increasingly recognized, housing and housing-related services are critical to enabling people with serious mental illnesses to live successfully in their communities. Yet mental health service systems have been reluctant to assume full responsibility for providing housing to these individuals, who are disproportionately homeless. Unlike other essential community-based services, housing cannot be covered under the Medicaid program, which guarantees states federal reimbursement for between 50% and 83% of the cost of services. Instead, service systems rely on federal housing assistance programs and, where available, on state or local housing subsidy programs.

Mental health services systems could make housing more widely available if they could use Medicaid funds for housing.

Mental health service systems could make housing more widely available if they could use Medicaid funds for housing. Although the Medicaid statute bars federal funding for "room and board," over the past several years the federal government has granted to more than half the states Medicaid "demonstration waivers" that lift a similar statutory prohibition: the rule barring Medicaid payments for services to individuals ages 21 to 64 in psychiatric institutions, or the institutions for mental disease (IMD) exclusion. If these waivers were lawfully granted, there is no reason why the ban on "room and board" could not be similarly waived in demonstration projects. Both the IMD exclusion and the "room and board" exclusion bar federal Medicaid funds for those services; if one exclusion can be waived, so can the other. If demonstrations show that Medicaid financing for housing improves mental health outcomes and reduces use of more costly services, those results should spur a conversation about modifying Medicaid rules to allow reimbursement for housing in appropriate circumstances.

2 Housing as a Social Determinant of Health

It is well established that housing is "one of the most basic and powerful" social determinants of health, particularly for individuals with serious mental illness (1, 2). People with serious mental illness experience homelessness at disproportionately high rates (3). The availability of housing can dictate their health outcomes (1).

Indeed, although mental health systems once considered the provision of mainstream housing outside their responsibility (although they have long funded group homes), an increasing number of state mental health systems have recognized the key role that housing plays in reducing inpatient psychiatric and substance use disorder admissions, emergency room visits, and overall Medicaid expenditures (4, 5). As a result, supportive housing has become an important part of the service array in many state mental health systems. Supportive housing, which combines a housing subsidy with a flexible, individualized package of supportive services, is a critical component in promoting mental health recovery and community integration and reducing institutionalization and incarceration (6).

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The federal government has similarly recognized the importance of housing in promoting good health outcomes and complying with the "integration mandate" of the Americans With Disabilities Act (ADA). In 2015, the Centers for Medicare and Medicaid Services (CMS) issued a bulletin describing housing-related services coverable through the Medicaid program (7). CMS explained that these services were critical to expanding home and community-based services consistent with the ADA's integration mandate and the Supreme Court's Olmstead decision (7). Although the services described do not include housing, they include a wide array of services that help people transition to living in their own home and support people in maintaining tenancy. A number of states have opted to cover these services, primarily through Medicaid demonstration waivers (8, 9). In 2018, CMS approved a North Carolina Medicaid demonstration waiver covering short-term housing, including mainstream apartments for individuals facing homelessness upon discharge from the hospital (10). North Carolina remains the only state with a waiver that includes coverage for housing.

More recently, Health and Human Services Secretary Alex Azar spoke about exploring how flexibilities might be offered within federal health programs, including Medicaid and Medicare, to allow payment for social determinants of health, such as housing and food (11).

In 2015, the Centers for Medicare and Medicaid Services (CMS) issued a bulletin describing housing-related services coverable through the Medicaid program.

3 Underinvestment in and Shortages of Affordable Housing

Underinvestment in housing has meant significant shortages of affordable housing for individuals with serious mental illness. Despite housing's key role in promoting recovery, community integration, and good health and mental health outcomes, mental health systems struggle to ensure that needed housing is available for the people they serve. Mainstream housing subsidies remain out of reach of many eligible individuals with mental illness (12). Many remain needlessly in institutions or cycle between homelessness, emergency rooms, inpatient admissions, and incarceration because of their inability to access housing. Although community mental health services remain in short supply across the country, it is the lack of access to housing that poses the biggest barrier to community integration (13).

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Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI), the main sources of income for large numbers of people in the public mental health system, are insufficient to cover market rents in most areas of the United States. Priced Out, a biennial publication providing data on housing affordability for people with disabilities, has consistently shown that subsistence benefits are insufficient to cover housing costs across the country (14).

This is a solvable problem. Rental subsidies and other strategies can and have been used to make housing affordable and available to people with disabilities. However, states have not invested sufficient dollars to provide access to community housing. Existing federal and state subsidy programs that have been the primary source of housing assistance to public mental health system clients are limited and do not meet the need. Although the federal Section 811 supportive housing program provides subsidized housing for people with disabilities, funding is limited, especially relative to need. In addition, most Section 811 subsidies are attached to a particular unit rather than to a person; if the person has to move, he or she cannot take the subsidy to a new unit. The more mobile Section 8 housing subsidies for low-income individuals are scarce, and typically there are long waiting lists for them. Moreover, federal rules bar individuals with certain criminal histories from receiving Section 8 subsidies. Other federal housing funding streams, such as the Continuum of Care program, are similarly limited in scope.

All of these federal housing programs are dependent on congressional appropriations each year. Some states, such as New York, offer rental subsidies as part of their "supported housing" service package for individuals with serious mental illness. However, these state subsidy programs also rely on discretionary spending. Further, state mental health authorities do not view housing as their primary mission (13). Even New York's program, which may be the nation's largest, is far too small to meet the needs of all who qualify. A funding structure that incentivizes bigger investments in housing would make a significant difference.

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The availability of federal Medicaid matching funds has been a significant incentive for states to invest in community services. In fact, because of this incentive, Medicaid has become the primary payer of public mental health services. There should be a similar incentive for states to invest in housing. To date, the federal government has interpreted Medicaid law as excluding coverage for "room and board" in community settings. Room and board is specifically excluded from coverage in Medicaid home and community-based services waivers and state plan options (15). However, Medicaid's "rehabilitative services" option, which funds most community mental health services, does not specifically address whether room and board is within its purview, and its language could conceivably cover housing. It covers "diagnostic, screening, preventive, and rehabilitative services, including . . . any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level" (16). Nevertheless, the federal government views room and board as excluded from Medicaid coverage in all home and community-based settings (17).

Thus, although housing has been embraced by mental health systems as a core part of what is needed for recovery, integration, and other positive health and life outcomes, Medicaid funding remains unavailable to support it.

4 Waiving Medicaid's Bar on Federal Payments

The federal government could waive Medicaid's bar on federal payments to cover housing in demonstration projects. The federal government has used Medicaid demonstration waivers in a majority of states to pay for services for which the Medicaid statute prohibits federal payment—specifically, as noted above, the IMD exclusion. Demonstration waivers allow federal payment for costs that might not otherwise be reimbursable under Medicaid. The payments are allowed as part of an experiment to test new policies that would further the objectives of the Medicaid program for the period and to the extent necessary to carry out the experiment.

Although one may argue that demonstration waivers cannot or should not allow payments that are explicitly prohibited by the Medicaid statute, the federal government is using these waivers to make such prohibited payments for services in IMDs. The Medicaid statute identifies specific provisions that can be waived in demonstration waivers (18), which do not include either the IMD or the "room and board" exclusion. Arguably, the federal government's waiver authority is limited to these identified provisions, but the federal government has taken a different position and has allowed demonstration waivers for services in IMDs. If the federal government can grant such waivers, it should be able to do so for housing ("room and board") as well. As described below, there is more reason to grant these waivers for housing than for services in IMDs. Moreover, expanding access to housing would avert the need for many IMD admissions and allow people to remain in their own homes.

The federal government could waive Medicaid's bar on federal payments to cover housing in demonstration projects.

The Medicaid IMD exclusion generally prohibits federal Medicaid payments for services provided to individuals ages 21 to 64 in IMDs (19). Despite this prohibition, in 2015 the federal government issued guidance encouraging states to seek demonstration waivers of the IMD rule for individuals needing substance use disorder services (20), and in 2018 it issued a similar guidance concerning services in IMDs for individuals with mental illness (17). The government has approved waivers in more than half of the states to pay for individuals in IMDs. The bulk have been for services for individuals with substance use disorders, but recent waivers have included IMD services for individuals with mental illness.

Waivers that allow reimbursement for housing could be designed consistently with the following requirements for Medicaid demonstration waivers: evaluating a hypothesis about a proposed innovation, furthering the goals of Medicaid, and maintaining budget neutrality. These were the requirements the federal government applied in granting the IMD waivers.

Studies have shown that supportive housing improves housing stability, reduces hospitalization, and increases life satisfaction, including for individuals with significant psychiatric disabilities, compared with more traditional mental health housing options.

Indeed, demonstration waivers covering housing may provide better and more valuable testing opportunities than the IMD demonstration waivers that have been granted. Medicaid coverage of housing subsidies could test important hypotheses related to using Medicaid-financed housing subsidies to improve mental health outcomes and reduce other health service utilization. Studies have shown that supportive housing improves housing stability, reduces hospitalization, and increases life satisfaction, including for individuals with significant psychiatric disabilities, compared with more traditional mental health housing options (21). Supportive housing has also been shown to significantly reduce costs for general medical and mental health services, including hospital, emergency department, homeless shelter, and jail costs, and to save money (22, 23) or result in similar net costs (24) when provided to people who were homeless. Medicaid demonstration waivers would provide the opportunity to test whether Medicaid coverage of supportive housing would produce similar outcomes, including whether and how much the use of Medicaid-financed services would be reduced. The questions being tested by the IMD demonstration waivers, on the other hand, have largely been answered. Those hypotheses—that federal Medicaid payments for short-term stays in IMDs will reduce use of emergency rooms, avoid inadequate care in general hospitals, and improve discharge planning and linkage to community-based services (17)—were tested in a large federal demonstration study and were not borne out (25, 26).

A demonstration waiver paying for housing subsidies would further a primary goal of the Medicaid program: furnishing health care coverage.

A demonstration waiver paying for housing subsidies would further a primary goal of the Medicaid program: furnishing health care coverage (27, 28). Expanding Medicaid enrollees' access to housing would reduce the risk of losing coverage—a risk that comes with homelessness and unstable housing. People who are homeless or have unstable housing have difficulty obtaining and staying on Medicaid and SSI (for many people with disabilities, particularly in states that have chosen not to expand Medicaid as authorized in the Affordable Care Act, receipt of SSI benefits is the primary avenue through which they qualify for Medicaid). For those with serious mental illness or substance use disorders, the challenges can be even greater (29). Indeed, the Substance Abuse and Mental Health Services Administration established the SSI/SSDI Outreach, Access, and Recovery (SOAR) program precisely to address these challenges. Access to stable housing could help prevent many Medicaid-eligible individuals from losing or failing to secure coverage.

Finally, a demonstration waiver covering housing could be tailored to ensure budget neutrality, which CMS has required before approval of demonstration waivers (30). Waivers could target individuals with serious mental illness exiting, or at risk of entering, institutional or correctional settings and who have no place to live. Covering housing for a short period, such as 6 months, would avoid discharges to homelessness, which often lead to readmissions, and would enable service providers to work with individuals to secure more permanent housing. Coverage could exclude the portion of housing costs expected to be paid with an individual's SSI or other income. Additional targeting criteria could include a history of hospitalizations, emergency department visits, or criminal justice involvement. North Carolina's demonstration waiver, for example, uses both specific needs-based criteria—targeting individuals who will be homeless posthospitalization and for whom housing is not available under any other program—and time limitations—not to exceed 6 months—to ensure that housing payments maintain budget neutrality. Moreover, the extensive research showing that supportive housing reduces utilization of other costly services, such as services in emergency departments, hospitals, and nursing homes, supports the notion that Medicaid payments for housing will not be too costly, because they will reduce use of other, often costly, Medicaid services.

As noted, the IMD waivers granted by the federal government are inconsistent with the Medicaid statute's demonstration waiver authority (18). The federal government has argued otherwise, asserting that it has general authority to spend money in otherwise prohibited ways. This interpretation contradicts the plain language of the statute. But if the government believes it can use its waiver authority to pay for services in IMDs, it should similarly do so to pay for housing. As noted, a stronger case can be made for demonstration waivers to cover housing; such waivers would test important hypotheses, and there is good reason to believe that these hypotheses will prove to be true. Moreover, unlike the IMD waivers that the government has granted, a demonstration waiver covering housing would not require waiving a provision that the statute forbids waiving; the exclusions of coverage for room and board exist only in certain Medicaid programs (15) but not under the rehabilitative services option, which is broad enough to cover housing. Although the federal government could arguably grant states permission to cover housing under the rehabilitative services option, its current view that Medicaid does not cover mainstream housing in the community would preclude that. The federal government's view of Medicaid would, however, enable its approval of demonstration waivers to cover such housing. If those waivers produce good outcomes, clarification of Medicaid regulations or statutory provisions could pave the way for covering housing on a more permanent basis.

Housing is an essential part of good mental health care.

Housing is an essential part of good mental health care. It is time that we explored including it as part of our primary system of health care for individuals being served in public mental health systems.

References

1/ Housing Is the Best Medicine: Supportive Housing and the Social Determinants of Health. New York, Corporation for Supportive Housing, 2014. Available here https://www.csh.org/wp-content/uploads/2014/07/SocialDeterminantsofHealth_2014.pdf.

2/ Ortiz SE, Johannes BL: Building the case for housing policy: understanding public beliefs about housing affordability as a key social determinant of health. SSM Popul Health 6:63–71, 2018.

3/ Mental Illness and Homelessness. Washington, DC, National Coalition for the Homeless, 2009. Available here https://www.nationalhomeless.org/factsheets/Mental_Illness.pdf.

4/ Housing Is Healthcare: Supportive Housing Evaluation. Albany, New York State Dept. of Health, 2019. Available here https://www.health.ny.gov/health_care/medicaid/redesign/supportive_housing/evaluation.htm.

5/ Addressing the Social Determinants of Health in the Second Phase of Health System Transformation: Recommendations for Oregon's CCO Model—Report and Recommendations. Salem, Oregon Medicaid Advisory Committee, 2018. Available here https://www.oregon.gov/oha/HPA/HP-MAC/Documents/MAC_AddressingSDOH_CCOmodel_Recommendations_FINAL.pdf.

6/ Behavioral Health Services for People Who Are Homeless. Treatment Improvement Protocol (TIP) Series, no 55. Rockville, MD, Substance Abuse and Mental Health Services Administration, 2013. Available here https://www.ncbi.nlm.nih.gov/books/NBK138725/pdf/Bookshelf_NBK138725.pdf.

7/ Coverage of Housing-Related Activities and Services for Individuals with Disabilities. Baltimore, Centers for Medicare and Medicaid Services, June 26, 2015. Available here https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/CIB-06-26-2015.pdf.

8/ Tenancy Support Services in Medicaid, Updated January, 2017. New York, Corporation for Supportive Housing, Jan 2017. Available here https://www.csh.org/wp-content/uploads/2017/01/Health_SummaryStateAction_TenancySH_Services_-2017_01.pdf.

9/ Letter to Karen Kimsey, Virginia Department of Medical Assistance Services. Baltimore, Centers for Medicare and Medicaid Services, July 9, 2020. Available here https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/va/va-gov-access-plan-gap-ca.pdf.

10/ Letter to Dave Richard, North Carolina Department of Health and Human Services. Baltimore, Centers for Medicare and Medicaid Services, April 25, 2019. Available here https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nc/nc-medicaid-reform-ca.pdf.

11/ Azar AM: The Root of the Problem: America's Social Determinants of Health. Washington, DC, Department of Health and Human Services, Nov 14, 2018. Available here https://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/the-root-of-the-problem-americas-social-determinants-of-health.html.

12 / Newman S, Goldman H: Putting housing first, making housing last: housing policy for persons with severe mental illness. Am J Psychiatry 165:1242–1248, 2008.

13 / Martone K: The impact of failed housing policy on the public behavioral health system. Psychiatr Serv 65:313–314, 2014.

14 / Priced Out. Boston, Technical Assistance Collaborative, 2020. Available here http://www.tacinc.org/knowledge-resources/priced-out-v2/.

15 / 42 USC §§ 1396n(c)(1), 1396n(d)(1), 1396n(i)(1), 1396j(1), 1396(k)(1)(C).

16 / 42 USC § 1396d(a)(13).

17 / Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance. State Medical Director letter no 18-011. Baltimore, Centers for Medicare and Medicaid Services, Nov 13, 2018. Available here https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd18011.pdf.

18 / 42 USC § 1315(a)(1) (listing as waivable 42 USC §§ 302, 602, 654, 1202, 1352, 1382, and 1396a).

19 / 42 USC §§ 1396d(a)(30)(B), 1396d(i).

20 / New Service Delivery Opportunities for Individuals with a Substance Use Disorder. State Medical Director letter no 15-003. Baltimore, Centers for Medicare and Medicaid Services, July 27, 2015. Available here https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/SMD15003.pdf.

21 / Rogers ES, Kash-MacDonald M, Olschewski A: Systematic Review of Supported Housing Literature 1993–2008. Boston, Boston University, Sargent College, Center for Psychiatric Rehabilitation, 2009. Available here https://www.bu.edu/drrk/research-syntheses/psychiatric-disabilities/supported-housing/.

22 / Hunter SB, Harvey M, Briscombe B, et al: Evaluation of Housing for Health Permanent Supportive Housing Program. Santa Monica, CA, RAND Corp, 2017. Available here https://hiltonfoundation.org/wp-content/uploads/2019/10/RAND_Housing_for_Health_FullReport-3.pdf.

23 / Seligson A, Levanon S, Lim T, et al: New York/New York III Supportive Housing Evaluation: Interim Utilization and Cost Analysis. New York, New York City Department of Health and Mental Hygiene, New York City Human Resources Administration, and New York State Office of Mental Health, 2013. Available here https://shnny.org/images/uploads/NY-NY-III-Interim-Report.pdf.

24 / Culhane DP, Metraux S, Hadley T: Public service reductions associated with placement of homeless persons with severe mental illness in supportive housing. Hous Policy Debate 13:107–163, 2002.

25 / Medicaid Emergency Psychiatric Services Demonstration Evaluation: Final Report. Washington, DC, Mathematica Policy Research, Aug 18, 2016. Available here https://innovation.cms.gov/Files/reports/mepd-finalrpt.pdf.

26/ Mathis J: Medicaid's institutions for mental diseases (IMD) exclusion rule: a policy debate—argument to retain the IMD rule. Psychiatr Serv 70:4–6, 2019.

27/ 42 USC § 1396-1.

28/ Gresham v Azar, 2020 US App. LEXIS 4751 (DC Cir Feb 14, 2020).

29/ SSI/SSDI Outreach, Access, and Recovery (SOAR). Rockville, MD, Substance Abuse and Mental Health Services Administration, 2019. Available here https://www.samhsa.gov/homelessness-programs-resources/grant-programs-services/soar.

30/ Budget Neutrality Policies for Section 1115(a) Medicaid Demonstration Projects. State Medical Director letter no 18-009. Baltimore, Centers for Medicare and Medicaid Services, Aug 22, 2018. Available here https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd18009.pdf.

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