# VT Medicaid Permanent Supportive Housing (PSH) Assistance Program – Preliminary Findings from Stakeholder Process

Stakeholder Session

Conducted by the Technical Assistance Collaborative (TAC) on behalf of the VT Agency of Human Services (AHS)

# Permanent Supportive Housing

- Permanent Supportive Housing (PSH) refers to housing for people with the most complex needs that is affordable, upholds the rights of tenancy via a lease, and offers voluntary, individualized services and supports to help them maintain their housing.
- PSH is an evidence-based, key strategy for ending homelessness and expanding integrated community-based settings for people with disabilities and other chronic and complex conditions.

# Proposal

- Implement a Medicaid Permanent Supportive Housing (PSH) Assistance Program that provides services that Vermonters need to successfully transition into and maintain residency in permanent supportive housing
- To manage Program resources: CMS' approval includes an enrollment cap, prioritization criteria, and waitlist

# Methodology

- Interviews with 22 key partners, and held 7 in-person and virtual stakeholder listening sessions with over 100 participants from communities throughout Vermont
- 5 listening sessions with 23 people with lived experience of being unhoused and identifying as having a mental health or substance use disorder or other disability, and 1 listening session with 28 family members of people with intellectual and developmental disabilities (I/DD).
- Online surveys for providers/agency partners and people with lived experience (PWLE) and their family members: Provider Survey = 18 respondents; Lived Experience Survey = 10 respondents
- **~ 195 Stakeholders in Vermont**

# Methodology

- Interview guides were designed and used to maintain consistency across the interviews and listening sessions
- Focus on experience with certain services and systems; and current practices, challenges, barriers/gaps, and strengths that will impact successful implementation of the Program, and how the new benefit can best assist individuals to gain access to, and remain successful in, PSH

# What is working*

- The Housing First and Family Supportive Housing (FSH) programs
- Landlord mitigation funds (also called Risk Pools) as an important strategy for securing housing units for PSH programs
- Where allowable, Master Leasing was highlighted as effective for securing units for the population & allowing for more flexibility with tenant screening than many private landlords provide
- Financial empowerment services
- "SASH and SASH for All" program as an effective program for promoting housing stability for the target population
- Checking in with tenants at least weekly (or more depending on need) and keeping caseloads low for housing retention case management services
- Cross-system coordination of care models, case conferencing, and shared care planning
- Peer delivered services, and a community hub model in one area of the state

***for people in need of PSH***

# Biggest barriers and gaps*

- A severe shortage of housing options for people who are low-income and/or have disabilities in Vermont
- Ongoing housing retention services are not widely available
- A strong need for service engagement was described by people who are unhoused, especially those living outside or in their car, who reported not being actively engaged with homeless services/supports or medical care
- People who are unhoused need access to Mental Health and Substance Use Disorder (SUD) treatment options
- A strong need for more homeless response system options for people in housing crisis was reported, especially in more rural areas of the state
- The lack of transportation options is preventing employment, access to food, and health care and exacerbating homelessness
- The benefits cliff is keeping people unhoused and contributing to food insecurity

***for people in need of PSH***

# What success would look like*

- Addressing urgent issues in substance use and mental health care for the target population
- Clear program guidelines and guidance on how people can access the Program
- A program that fills the gaps in the current state structure, and creates alignment and synergy with existing housing services programs
- Using data to inform priorities and set performance metrics and revisit them regularly
- Helping eligible individuals develop independence and be able to identify housing stock in the community that they can eventually "move on" to
- Providing adequate wages and hazard pay for staff delivering the services
- Successful engagement, referral, and tenancy for the eligible population
- Utilizing the Program services to leverage more affordable housing partners and units for people who are unhoused

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# Biggest concerns for implementation*

- Workforce capacity issues related to staff turnover, wages, and vacancies
- The serious lack of housing stock and affordable housing options
- That ground level, grassroots housing/homeless service providers will be left behind as they lack the infrastructure to be able to bill Medicaid
- There will be too many qualifying criteria and parameters on what can be provided, a complicated and inaccessible application process, complicated billing processes, and excessive reporting and data collection
- The lack of these services or a structure to support the program in some areas of the state, including not having enough staff to support the program
- That people living with complex mental health needs and those with the most high needs overall will not have access to the Program

***of the new Medicaid PSH Program***

# Biggest opportunities*

- Expanding the Housing First program and trauma-informed care
- Expanding and sustaining successful PSH models
- Helping more families and individuals with complex barrier to be housed
- Setting rates and caseloads that will address burn-out and overloaded direct service staff
- Addressing gaps in the system for people in substance use disorder recovery. Respondents highlighted the following needs:
  - Incorporate recovery housing
  - Create more harm reduction housing
  - Address the urgency of substance use disorder issues
- Assisting those who are falling through the cracks
- Supporting people trying to re-enter the community from incarceration

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# Enhancing service and system coordination

- Stronger coordination across various providers/systems doing similar work (i.e. Domestic Violence, CAP agencies, DAs, homeless services providers). Multiple agencies duplicate certain efforts and it can be confusing for people being served.
  - More collaborative efforts across organizations and sectors
  - Joint care planning and case conferencing
  - Education and training on who is eligible for what program, and how to navigate the various systems and programs was frequently noted.
- The need for better state level coordination and communication as it relates to contracting, eligibility criteria, program standards, data collection and sharing, and quality assurance
- A lack of a coordinated, centralized process/system for coordinating referrals for community based housing options for people with I/DD at the state level

# Suggestions for delivering the new Medicaid Program

- Ground level housing/homeless organizations have deep experience with the population and may be the most appropriate providers to deliver the new Program, however, they have challenges and barriers to billing Medicaid directly
- Strong preference for a per member per month rate (PMPM), and opposition to a Fee for Service (FFS) model due to administrative burden
- Support for an intermediary option for purposes of managing the Medicaid billing components.
- Small organizations don’t have clinicians and don’t fit the "medical model" and stressed that flexibility will be key to success
- The need for Medicaid reimbursement for peer support (i.e. mental health, SUD, and housing/homelessness)
- Importance of appropriate caseloads and the need for adequate rates to support the benefit
- Look to the FSH program approach for enrolling providers in Medicaid and payment methodology
- Federally Qualified Health Centers (FQHCs) were highlighted as potential providers of the new housing services who could partner with housing agencies and embed staff in their buildings

# Prioritization of the new Program

- Strong concerns about crime, violence, drug use and deplorable conditions in hotels and on the streets were reported by people with lived experience and provider staff and should inform the prioritization strategy
  - Families with children living in hotels were repeatedly raised as the most vulnerable populations in need of prioritization
  - Individuals with long consecutive stretches or multiple stays should be considered for prioritization
- Coordinated Entry Systems (CES) should be used to prioritize eligible individuals and families who are experiencing homelessness
- Populations identified as likely to fall through the cracks:
  - Domestic Violence victims
  - Parents who disengage from systems due to fears of losing their children
  - People who are unhoused and employed with low wage jobs were identified as not eligible/prioritized for housing programs but having no other housing options
- People with high rates of inpatient psychiatric visits and high level of care needs

# Training and Quality Assurance

- There is a need for the state to support training and technical assistance and to promote consistency across PSH programs
- FSH was cited as an effective model of quality assurance for PSH and for bringing consistency with training and data collection
  - Training is required for FSH providers and a mandatory quarterly community of practice meeting
  - The monthly payment rate allows for staff to engage in onboarding requirements and training. Every program is expected to have a line item for Training & Technical Assistance
- Respondents shared that PSH providers need more expertise on the model, and training on fair housing, understanding resources and benefits, and disabilities

# Strategies to address equity in access for disenfranchised populations

- There are some Diversity Equity and Inclusion (DEI) efforts going but they are varied and inconsistent across the state, especially as it relates to analyzing data
- CES was highlighted as the most notable equity strategy currently in place
- Respondents reported inequitable treatment of people with disabilities, especially serous mental illness and SUDs
- The lack of translation services was repeatedly cited as an equity issue
- Small agencies don't have capacity to focus on equity data and outcomes. State funding connected to intentional deliverables around health equity was recommended
- One homeless services provider was undertaking a DEI initiative using mobile outreach vans to engage hard to reach people
- The provider qualifications for the new Program were raised as an equity issue with concern that the Bachelor degree requirement will exclude staff who bring critical life and work experience

# Alignment of Peer Support services with the new Program

- Multiple respondents, including many people with lived experience, emphasized the importance of lived experience in service provision
- Intentional Peer Support was highlighted as an effective model for PSH that is not widely available
- Respondents expressed a need for statewide training and professional development of a peer support workforce

# Thank you!

- Please feel free to contact Alicia Woodsby at awoodsby@tacinc.org with any additional questions or feedback.