Housing – 1115 Waiver Services Framework

DC MCAC HSR – Discussions

Service Name:	Housing Navigation Services	Pre-Tenancy Services	Tenancy-Sustaining Services

Service Description:	Participants noted that housing navigation and pre-tenancy services were largely aligned with the Housing Supportive Services benefit, including:
	• Housing search, including identification of suitable supportive or transitional housing
	• Identification of resources or income for housing (this being more challenging and intensive than HSS for low-income beneficiaries without a matched housing resource)
	• Obtaining documents need to secure housing
	• Assistance with housing applications and communication with prospective housing placements, including gathering clinical information to support placement in higher levels of care, such as assisted living and community residential facilities
	• Assisting with move-in and transition needs, including food, clothing, and household furnishings
	• Support with securing any supportive services that are needed, such as home health or assertive community treatment
	• Assist with linking to resources and supports to address behavioral health, medical needs, and social determinants of health
	• Housing navigation services are more intensive and time-limited than pre-navigation services because they are linked to care transitions and urgent supportive housing needs
	• Several participants stated care coordination for medical, behavioral health, and social needs is
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		• Identification of resources or income for housing (this being more challenging and intensive than HSS for low-income beneficiaries without a matched housing resource)
		• Obtaining documents need to secure housing
		• Assistance with housing applications and communication with prospective housing placements, including gathering clinical information to support placement in higher levels of care, such as assisted living and community residential facilities
		• Assisting with move-in and transition needs, including food, clothing, and household furnishings
		• Support with securing any supportive services that are needed, such as home health or assertive community treatment
		• Assist with linking to resources and supports to address behavioral health, medical needs, and social determinants of health
		• Pre-tenancy services that are not linked to a housing voucher resource may be more complex and time-intensive due to shortage of appropriate housing for very low income beneficiaries
		• Several participants stated care coordination for medical, behavioral health, and social needs is
			Participants noted that housing tenancy-sustaining services were largely aligned with the Housing Supportive Services benefit.
			• Participants noted that without a designated housing resource (matched voucher), assistance for individuals who are in danger of losing housing, or need new placement may be more complex and time-intensive due to shortage of appropriate housing for very-low income beneficiaries
			• Participants noted that service should be provided on a time-limited basis to prevent loss of housing to individuals not receiving HSS as a prevention service
			• Participants noted that there are many housing units appropriate for high-need Medicaid beneficiaries that either fall outside the continuum of care (non-HUD CoC, non-Permanent Supportive Housing) or lack sustaining service funding, for example:
			  ○ 811 Capital Advance
			  ○ HCV vouchers (DC Housing)
			  ○ Non-Elderly Disabled (NED)
			  ○ Nonprofits with affordable housing
			• Several participants suggested mapping these housing resources to explore whether 1115 HRSN services could expand housing options for Medicaid beneficiaries in care transitions
			• Several participants stated c are coordination for medical, behavioral health, and social needs is necessary and must be provided to enable housing to be maintained

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	necessary and must be provided to enable housing search • Several participants noted comprehensive assessment and intake are necessary to develop appropriate housing plan	necessary and must be provided to enable housing search • Several participants noted comprehensive assessment and intake are necessary to develop appropriate housing plan	○ Care coordination could be strengthened with CRISP/HIE to support better connection of health and housing supports ○ Consider specialized population health supports such as nurse care manager for every 100 or more tenants with complex health needs • Housekeeping services may be necessary for high-need individuals to prevent loss of housing (for example to address behaviors such as hoarding or lack of hygiene that may result in eviction) • Comprehensive assessment and intake are necessary to develop appropriate housing plan
Beneficiary Eligibility Criteria:	Participants suggested wide range of beneficiaries that would benefit from the service, including the following groups: • Medicaid beneficiary • Unhoused/risk of • Transfer from Foster Care • Emergent housing • Care transitions • Participants noted that priority populations should include individuals requiring reentry support, substance use treatment, or mental health services, with additional focus on women with children and individuals recovering from opioid use.	Participants suggested wide range of beneficiaries that would benefit from the service, including the following groups: • Medicaid beneficiary • Unhoused/risk of • Transfer from Foster Care • Emergent housing • Care transitions, such as IMDs and medical respite. • Participants noted that priority populations should include individuals requiring reentry support, substance use treatment, or mental health services, with additional focus on women with children and individuals recovering from opioid use.	Participants suggested wide range of beneficiaries that would benefit from the service, including the following groups: • Medicaid beneficiary • Unhoused/risk of • Transfer from Foster Care • Emergent housing • Care transitions • Beneficiaries at risk of losing housing needing prevention services • Participants noted that priority populations should include individuals requiring reentry support, substance use treatment, or mental health services, with additional focus on women with children and individuals recovering from opioid use.
Frequency:	Intensity varies according to need, minimum of weekly likely needed; but may require more frequent to support very-low income or high acuity, for example zero income or individuals that need long term care	Intensity varies according to need, minimum of weekly likely needed; but may require more frequent to support very-low income or high acuity, for example zero income or individuals that need long term care	Intensity varies according to need, minimum of weekly likely needed for individuals at risk of losing housing that are very-low income or high acuity, for example zero income or individuals that need long term care • Individuals maintaining appropriate housing require less-intensive services that are person-centered

Duration:	It was noted that services would typically range from 30 to 90 days, with extensions up to 180 days based on individual circumstances, including: • Care transition • Assistance with placement to higher levels of care • Assistance for very-low income • Step-down services required for SUD recovery • Medical necessity • Completion of the eligibility process	Aligns with housing transition services and HSS It was noted that services would typically range from 30 to 90 days, with extensions up to 180 days based on individual circumstances	Duration varies according to beneficiary need • It was noted that services for individuals at risk of losing housing may range from 30 to 90 days, with extensions up to 180 days based on individual circumstances • Long-term tenancy-sustaining services are required to support beneficiaries with disabilities or histories of chronic homelessness, recommend extending up to 2 years or more • Long-term tenancy-sustaining services could be paired with affordable units to support beneficiaries with disabilities or histories of chronic homelessness

Setting:	Aligns with HSS
	• Community and office-based
	• Participants emphasized that services should be delivered in one of the following settings as part of discharge or transition planning:
	  ○ Accredited community-based facilities with wrap-around services
	  ○ Medical respite facilities
	  ○ Residential (IMD) facilities
		Aligns with HSS
		• Community and office-based
			Aligns with HSS
			• Community and office-based

Provider Staffing Qualifications:	It was suggested that each program should include at least one Navigator, responsible for: • Addressing SDOH-related needs • Completing eligibility forms and reconsiderations • Implementing preventative measures to maintain beneficiaries' program coverage and avoid lapses in deadlines • Care team should include physician or clinician to address additional health concerns and enhance service effectiveness • Professional experience should align with HSS, including role of individuals with lived experience	It was suggested that each program should include at least one Navigator, responsible for: • Addressing SDOH-related needs • Completing eligibility forms and reconsiderations • Implementing preventative measures to maintain beneficiaries' program coverage and avoid lapses in deadlines • Care team should include physician or clinician to address additional health concerns and enhance service effectiveness • Professional experience should align with HSS, including role of individuals with lived experience	It was suggested that each program should include at least one Navigator, responsible for: • Addressing SDOH-related needs • Completing eligibility forms and reconsiderations • Implementing preventative measures to maintain beneficiaries' program coverage and avoid lapses in deadlines • Care team should include physician or clinician to address additional health concerns and enhance service effectiveness • Professional experience should align with HSS, including role of individuals with lived experience

		• Nurse care manager for every 100 or more tenants with complex health needs to provide specialized support	• Nurse care manager for every 100 or more tenants with complex health needs to provide specialized support
Staffing Ratio/ Caseload:	Aligns with HSS, may differ depending on setting and intensity	Aligns with HSS, may differ depending on setting and intensity	Aligns with HSS, may differ depending on setting and intensity
Other Considerations:	Most group members suggested including an on-site physician or clinician within the program to address additional health concerns and enhance service effectiveness.	Nothing was explicitly discussed during this session.	Nothing was explicitly discussed during this session.

Nutrition – 1115 Waiver Services Framework

DC MCAC HSR – Discussions

Service Name:	Meal Program (Home Delivered) Service
Service Description:	Participants discussed considerations for medically tailored meals (aligned with FIMC MTM accreditation standards), medically supportive meals, and nutritionally complete meals based on USDA Dietary Guidelines. The group referenced the following resources for additional context: USDA Dietary Guidelines; https://www.mass.gov/doc/hrsn-supplemental-services-manual-nutrition-2/download • It was noted that clear distinctions between medically tailored, and nutritionally complete meals, would be necessary for defining program standards. • It was noted that medically tailored meals should be fully prepared, approved by a Registered Dietitian Nutritionist (RDN), and delivered directly to enrollees' homes to meet their nutritional needs based on medical diagnoses. • Participants emphasized the importance of tailoring meals to support specific qualifying diagnoses, such as prenatal, pregnancy, and postpartum conditions, and ensuring menus provide sufficient variety within dietary restrictions (e.g., low-sodium options). • Participants suggested exploring ways to allow beneficiaries to pre-select meals to enhance satisfaction while adhering to nutritional requirements. It was noted that service descriptions should include these considerations to ensure program effectiveness. • The scalability of standardized meals and opportunities for personalization were also discussed, with suggestions to operationalize beneficiary preferences in the final service descriptions. Participants highlighted the need to balance flexibility in menu options with adherence to evidence-based nutritional guidelines. It was suggested that finalized service descriptions should account for both program feasibility and beneficiary needs.
Beneficiary Eligibility Criteria:	Participants discussed various factors for determining eligibility criteria for meal services, emphasizing inclusivity and actionable guidelines: • It was noted that eligibility criteria should evaluate whether beneficiaries can prepare meals due to physical or mental limitations. Some other states have restricted meal services to individuals unable to prepare meals themselves. • Participants suggested that Z-codes could serve as a useful tool for identifying eligible beneficiaries. • Participants explored whether eligibility should extend to entire households or remain limited to the individual beneficiary, noting CMS guidance allows broader eligibility for certain conditions, such as pregnancy. • Reference was made to tiered food security scales, including self-attestation of clinical risk factors, as a potential means to reduce access barriers. • Widely used tools, such as the Hunger Vital Sign screener, were highlighted as effective methods for assessing food hardship and determining eligibility. • Expanding eligibility to include family-level risks, such as considering a child eligible if a parent has a qualifying diagnosis, was suggested for further exploration. • The variability in beneficiaries' ability to prepare meals on a day-to-day basis was noted as a consideration. • Participants suggested adopting broader screening criteria that account for general health-related social needs rather than focusing narrowly on specific needs like housing. Multiple participants highlighted the importance of refining eligibility criteria to balance inclusivity with clarity and operational feasibility. It was noted that clearly defined and actionable guidelines would be critical for successful implementation.
Frequency:	Participants discussed the frequency of meal delivery and considerations for tailoring the program to meet beneficiaries' varying needs: • It was suggested that providing up to three meals per day could be justified for individuals unable to prepare meals independently. However, diagnosis-specific or health-related social needs may require fewer meals.

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	• Some participants suggested evaluating whether the program is the most appropriate solution for individuals unable to prepare meals, noting that alternative options like institutional care might better address long-term needs. • Participants highlighted the importance of flexibility in program design, recommending language such as "up to three meals a day, up to seven days a week" to address varying beneficiary needs and provider capabilities. • It was suggested that incorporating "up to" language in program descriptions allows for adaptability without reducing the program's potential benefits. • Participants highlighted the need for clearly defined caloric ranges or macronutrient ratios, emphasizing the importance of quality over quantity in meal offerings. Multiple participants highlighted that flexibility and clarity in program design, coupled with clear nutritional standards, would enhance the program's ability to meet diverse beneficiary needs effectively.
Duration:	Participants discussed program durations, noting a general timeframe of up to six months with extensions as needed based on individual circumstances. For pregnancy-related cases, it was suggested that service durations align with the pregnancy term and include postpartum periods, such as 6-12 weeks following delivery or based on the timing of the last medical checkup. Flexibility was highlighted as essential to accommodate the varying needs of beneficiaries while ensuring effective support.
Setting:	Participants suggested that services should primarily be delivered to beneficiaries in their private residences.
Provider Staffing Qualifications:	Participants discussed considerations for staffing qualifications and noted the need for standards that align with program goals and beneficiary needs. Examples referenced include the Food Is Medicine Coalition (FIMC) Medically Tailored Meal (MTM) Accreditation Program, which outlines roles such as Registered Dietitian Nutritionists (RDNs) responsible for meal composition, client eligibility, and tailored nutrition counseling based on clinical guidelines. • It was suggested that staffing qualifications consider prior service delivery experience, such as a history of providing similar services or a minimum number of years in a relevant field. • Participants noted that flexibility in staffing models, including the option for contracting or volunteering, could support tailored meal delivery for beneficiaries with specific medical needs. • Suggestions included educational initiatives for staff, such as training in nutrition or culinary education, to enhance service delivery and participant engagement. • It was proposed that training programs include curricula on addressing health-related social needs (HRSN) and customer service skills to improve program outcomes. • Participants highlighted the potential value of prioritizing local or nonprofit organizations for grants and contracts to strengthen community-based service delivery and align with funding requirements. Multiple participants highlighted the importance of establishing qualifications that ensure staff are equipped to deliver high-quality, tailored services while supporting the program’s overall mission.
Staffing Ratio/ Caseload:	Participants noted that FIMC MTM Accreditation recommends one full-time RDN for every 1,000 clients. Discussions highlighted the need to clarify RDN responsibilities, particularly when educational duties are included. Suggestions were made to leverage technology partners to enhance delivery efficiency and support staffing needs.
Other Considerations:	Nothing was explicitly discussed during this session.

Reentry – 1115 Waiver Services Framework

DC MCAC HSR – Discussions

Service Name:	Behavioral Health Counseling and Therapy	Peer Support Services
Service Description:	The following considerations were suggested by participants: • Completing assessments before individuals transition from incarceration, with pre-release engagement to establish relationships, clarify meeting details, and support a smoother transition. o If pre-release engagement is not possible, these activities should occur immediately after release. • Minimizing or eliminating waiting periods for psychiatric services upon release, with service needs identified and arranged prior to release. • Utilizing the waiver's allowance for behavioral health services to address identified needs, including diagnostic assessments to confirm behavioral health diagnoses. Therapy services, both in-person and via telehealth, were proposed to enhance engagement and readiness for reentry. • The importance of a full scope of services, such as substance use screenings and behavioral health support, as critical to reentry success.	• Participants suggested a broader definition of peers that include certified peer support specialists who are trained by the Department of Behavioral Health (DBH) to support individuals with substance use disorders and mental health conditions, and other support from trained individuals with lived experience (e.g. peer navigators) • Peer support services were described as playing key roles in both mental health and substance use disorder recovery, with peer navigators specifically focused on facilitating the provision of services during transitions. • DYRS shared that within the juvenile justice system, a peer support program is offered through "credible messengers," which operates on similar principles of peer support. It was suggested that there may be opportunities to review and enhance this system to expand peer support services and create additional opportunities for support.
Beneficiary Eligibility Criteria:	• DYRS shared that for youth in secure detention, if there is an indication for specific behavioral services, internal tools are used to assist with guiding decision-making on delivery of services. • When planning for a young person's discharge—at 90, 60, or 30 days—it is ideal for the individual to have had an initial assessment, potentially one or two reassessments, and a tailored plan in place. By the time of discharge, there should be a clear plan outlining the ongoing services the youth will need. Emphasis was placed on the importance of placing youth in services specifically tailored to their individual needs. • It was further suggested to use a measurement-based approach for screening, allowing results to inform decisions about who requires specific services (e.g., behavioral health, substance use disorder, trauma support). Specific interventions tailored to address the disproportionate percentage of individuals with trauma or untreated trauma were identified as particularly useful. Participants suggested that group therapy may require different eligibility criteria, such as individual's ability to participate appropriately in a group setting.	• Several participants suggested that the approach could remain broad, noting that the trauma associated with experiences before, during, and after incarceration supports making services accessible to all who request them. • In the context of behavioral health, it was suggested that tying services to assessments and identified needs could enhance their effectiveness. • Participants shared that connecting individuals with someone who has shared similar experiences might provide meaningful support and help align services with individual needs.

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Frequency:	Participants highlighted several key factors for structuring services: • It was suggested that the frequency of services align with assessments and individual risk levels, with current practices ranging from weekly to biweekly sessions.	• It was suggested that it should be linked to assessment and risk level (youth side), it was noted that youth transitioning back into the community may not always have opportunities to practice essential skills.
Duration:	• Participants noted that therapy services are currently time-based rather than level-of-care-based. Suggestions included utilizing assessments to better determine care levels and linking service reimbursement to care needs. • Recognizing diverse care requirements, participants proposed exploring behavioral health service tiers in future discussions.	• Participants suggested that duration should be tied to the goals of an individual's care plan
Setting:	• Participants noted ensuring confidentiality for both in-person and virtual services was emphasized, with Medicaid privacy requirements applicable to waiver services. • The Department of Corrections is considering soundproof booths to enhance privacy. Discussions included provider training needs, access to facility records, and the logistics of conducting assessments within facilities. • Some suggested that a hybrid model involving internal and external providers with telehealth accommodations was suggested. Facility-based services should integrate with electronic health records to ensure continuity post-release. • Some suggested that understanding the mix of in-person versus telehealth services was noted as vital for implementation. Differential rates for in-person and telehealth services were also proposed.	Nothing was explicitly discussed during this session. (will continue discussion at next meeting)
Provider Staffing Qualifications:	• Participants suggested that providers should meet the licensing requirements of their respective boards (e.g., licensed therapists, psychologists, psychiatrists, social workers, counselors). • Years of experience was identified as an important consideration. • Participants suggested that efforts should be made to reduce barriers, such as providing supervision for individuals who are not independently licensed. However, many participants expressed caution about lowering standards and emphasized the importance of maintaining high staff qualifications to ensure the quality of care provided. • Many participants noted that understanding best practices and standards of care is critical to ensuring successful transitions. It was observed that	Nothing was explicitly discussed during this session. (will continue discussion at next meeting)

	individuals often face more complex issues upon release due to receiving substandard care while incarcerated.	
Staffing Ratio/ Caseload:	Nothing was explicitly discussed during this session.	Nothing was explicitly discussed during this session. (will continue discussion at next meeting)
Other Considerations:	• Participants suggested educating individuals and providers on enrollment processes to improve care transitions and coordination. • Participants suggested reviewing examples of substandard care to identify opportunities for improvement. This could help inform plans to strengthen care standards and better support individuals transitioning back into the community.	Nothing was explicitly discussed during this session. (will continue discussion at next meeting)