for the purpose and the agenda for today. So attendees will be equipped to identify available housing-related supports, which we'll define in a moment, and services in their state and communities. Attendees will also be able to locate their state and local agencies responsible for funding and delivering these resources, in order to reach out and form partnerships to ensure successful referrals, lease-up, and ongoing tenancy in HUD housing programs, especially the Emergency Housing Voucher program.

And this webinar will also be helpful for PHAs, public housing authorities with a homeless admission preference, and PHAs with a special purpose voucher program, such as Mainstream, Family Unification Program, and HUD-VASH. So the agenda will be defining housing-related supports and services, and how these can be paired with HUD housing assistance to benefit individuals experiencing homelessness.

We will describe resources available through federal Health and Human Services agencies, specifically the Center for Medicare and Medicaid Services today, that can fund housing-related supports and services, including the new resources in the American Rescue Plan.

We'll offer a couple of examples of on-the-ground partnerships and pairing of HUD-HHS resources and takeaways for public housing authorities, and Continuums of Care, and others to learn more and pursue partnership opportunities. And then we'll take some questions and provide answers. Next slide, please.

OK, so we do want to just remind folks that this webinar is the second in a three-part series identifying Health and Human Services agency resources that can be used for housing support services, along with specific partnership opportunities and on-the-ground examples of successful approaches to pairing these resources. Next slide, please.

So we wanted to just pause for a moment and do a quick poll. And Ari's going to bring up our poll today. This will just give us a better sense of who's listening in, so that are our presenters have a little bit more context as to who's joining today's call.

So folks can select who you're associated with, a single choice. We'll just let this set up here for a second, and then we'll look at the results.

All right. So it looks like about 24% are with public housing agencies. 28% are with Continuum of Care. 3% with victim services. And then 45% with others. So we would love, if you have a moment in the Q&A, to just type in the other type of agency that you're affiliated with, and we'll take a look at the end.

Great. OK. Next slide, please.

So now we just want to make sure that we're all sort of on the same page, in terms of the language that we're using here when we're talking about housing-related supports and services. So these are really comprised of four different types of services.

The first of which is outreach and engagement referral services. So these are services that help identify and refer people experiencing homelessness to coordinated entry, to access housing assistance provided by the CoCs and public housing authorities. Then there are pre-tenancy services.

And I'll let you all take a look at that list of four. And public housing authorities, as you probably well know, are required to partner with Continuums of Care, or other homeless or victims' service providers, to assist qualifying families through a direct referral process. And MOUs between public housing authorities, and Continuums of Care, and other partners, were due on July 31st, and were to identify services provided to assist emergency housing voucher applicants and participants, including what is being offered to ensure that referrals are successful.

OK. Just taking a brief moment to look at any questions that may be queued up for now. Alicia, I'm just going to pause for a second, to see if we have any that need to be answered now, or if we're good to continue going.

And here's some of the most important, in my opinion. The statute requires that each service must be sufficient in duration, amount, and scope. The statute requires that services are available statewide throughout the state, to the extent feasible. The statute also requires that services are equal in amount, duration, and scope, for any individual within an eligibility group.

Also, individuals must have a choice of qualified provider. Choice of qualified provider, and any willing and qualified provider must be allowed to participate in Medicaid. Now, I mentioned that these are foundational provisions. But these provisions can be waived, when consistent with access, quality, and the efficient and economic provision of the services.

Sometimes services have waivers built into the service, such as targeted case management services, which allows a service to be limited geographically, or to certain groups, or to certain providers, for certain populations. But more about waivers later.

I'm going to talk briefly about Medicaid eligibility. And really, you could spend a whole week talking about each of these topics, easily. But hopefully this presentation will give you a bit of the language that is used in Medicaid, and you may feel a bit more comfortable working with your partners in Medicaid.

So anyway, the fourth fact you've always wanted to know about Medicaid, to be eligible, individuals must fit into a group. Some are mandatory, such as children under age 19, but others are optional, such as the medically needy group. Individuals also must meet income standards.

Now, looking at this slide, you can probably recognize many of your constituents here. I believe there may be over 60 Medicaid eligibility groups. So, your constituents will probably fit in somewhere. But again, for the optional groups this will vary by state.

Now, here's my favorite aspect of Medicaid, that you may have always wanted to know about. And Rachel and her colleagues have discussed some of these. But I'd like to connect the dots a bit, between what is really helpful to individuals needing housing support, and connect the dots with what is covered under Medicaid, and the language, again, that we use in Medicaid for these benefits.

This list, and I realize it's microscopic, probably, for you to review, but I'd like to draw your attention to 1905 of the Social Security Act, that does define these services, also 1915. Those are the official definitions of the services.

Also, not too long ago, we put out a State Health Official letter, a SHO, that talks about the social determinants of health, and how Medicaid covers these. And this is a really nice and user-friendly description of many better benefits, and especially in relationship to housing services and support. So I definitely invite you to take a look at that document. And we will mention it again, on one of the last slides we have here today.

But I do want to delve into a few of these that may be of special interest to you. On the left-hand column are mandatory services that all states offer. It's quite a broad benefit. But this probably looks a good bit like the kinds of services that we all have in our health insurance plans. But of special note is EPSDT.

We're constantly talking about acronyms here, but this stands for Early and Periodic Screening, Diagnostic, and Treatment Services. This is Medicaid's benefit for children. So children must have available all the services listed in 1905(a) of the act, whether they're mandatory or whether they're optional.

It's a comprehensive and a critical benefit. Yet I understand that only 60% of children who would qualify for Medicaid are enrolled. So you can help us out. Get children enrolled in Medicaid.

Other mandatory services include Federally Qualified Health Centers. Many of you are very familiar with FQHCs, and also rural health centers that offer a similar array of comprehensive services in the communities. Later on today, you're going to be hearing more from Washington state, who's doing some very cool activities with FQHCs. It's a mandatory service.

Home health services is also mandatory. It includes the services of nurses, home health aides, as well as medical equipment. And of course, these are provided in the home. Optional under that benefit are therapies. Transportation to medical appointments is also a mandatory service.

I want to come to community-based services. Now these fall in the category of optional Medicaid services, except for the ones that I just featured a couple of minutes ago. But I'd like to spend just a bit of time on this. Again, this is going to be a very high-level discussion, and it would be great if you would invite us back in some other venue to talk in great depth about these services.

But just to give you a flavor, and also to help demystify some of these numbers and letters on this slide, as well. I'm going to refer you back again to the social determinants of health state health officials letter, as well.

Personal care services is widely used within our home and community-based services venues, and it's human assistance to help individuals to accomplish the activities of daily living, or instrumental activities of daily living. Rehabilitative services is another category offered through the state plan that reduces physical and mental disability, and restores beneficiaries to the person's best possible functional level. Examples include counseling for individuals with mental health or substance use disorders, as well as the therapies, physical, occupational, and speech therapies.

Crisis services are also covered under this category. A premier service that you'll hear a lot about, you probably know a lot about already, for those working in Continuums of Care, is the section 1915(c), Home and Community Based Services, or waiver programs. This 1915(c) serves individuals who need the state's institutional level of care.

And that means that the individual could be admitted to a nursing facility, hospital, or an intermediate care facility for individuals with intellectual disorders or disabilities. States can target programs to specific populations and limit services geographically under 1915(c) waiver programs. The services include case management, home accessibility adaptations, one-time community transitions or cost, housing and tenancy supports, rehabilitation services, non-medical transportation, home delivered meals, supportive employment, and assisted technologies, as well as other types of services that may assist in diverting individuals from institutional placement, and supporting community living for eligible individuals.

So this is really a tremendously important program to delve into, and to find out how your state is providing this service. The sister service of 1915(c) waiver programs is the state plan Home and Community Based Services, or 1915(i), and it includes all the services I just mentioned, or the potential for including all of the services that I just mentioned. However, the eligibility for the participants differs.

And then we have 4% who selected other. So we'll close that. Thank you all so much for taking the time to answe those questions.

And with that, I think we're going to turn to questions now. And I will check in with my colleague, Alicia Woodsby, here.

I know that we do have a couple of questions that I have flagged, and so let me go ahead and maybe ask these questions of CMS and HUD. And then we'll see what other questions that we have.

So one question from an audience member who asked if a service provider can still partner with public housing authority and CoCs to offer services if they missed the July 31st MOU deadline. And HUD, would you like to answer that question?

SPEAKER 1: Hi, sorry, could you hear me?

RACHEL POST: Yes we can hear you now.

SPEAKER 1: OK, great. So the MOU requirement deadline was passed, but that doesn't mean that the MOU that was agreed upon between the PHA and the CoC cannot be amended.

So one thing that we've always stated is that the MOU is a living document, and as the PHA and CoC mature, the EHC program, and identify things such as additional services that you want to provide, this document can be amended. And I think there are also additional questions on whether we're collecting the MOU.

And so, no, we are not collecting the MOUs. Although some PHAs and/or CoCs have provided on the MOU to HUD. We've reached out to a couple PHAs from a technical assistance capacity, to see if we can help, but we aren't collecting them.

And we encourage PHAs and CoCs to always maintain accurate records, and have the latest copy of their MOU on hand. And so, the best place to go to find what's agreed upon between your PHA and CoC is at the PHA or the CoC.

RACHEL POST: Oh, I'm sorry, I lost that last part of your sentence.

SPEAKER 1: So HUD would not have the latest copy of the MOU.

RACHEL POST: Right.

SPEAKER 1: If it has been amended an additional time before the requirement deadline, the most up to date MOU should be requested from the PHA and/or the CoC.

RACHEL POST: Great, thank you. Another question we have is, and I think this is a question for CMS, where could public housing authorities and Continuums of Care find information about their state's optional benefits, and the agencies offering these services?

JEAN CLOSE: This is Jane, I'll take that one. And I mentioned that Medicaid.gov earlier, and I'm going to put this in the chat or the Q&As, that which is the best place. But on Medicaid.gov there's a benefits section, and there's a place that you can pick your state.

So I will put that out there, and it'll give, again, a very high-level indication of what the state benefits are provided. But hopefully there will be a resource for you to actually contact the state, or to access the state's website for additional information.

One thing I also didn't mention, for those who are seeking to establish partnerships within the state, CMS has a group, Medicaid and CHIP Operations Group, that really has a great relationship with each state, more so than the folks on the phone from CMS today.

So I'd also invite you to reach out to the Medicaid and CHIP Operations Group. And again, I will look for that link and put it in the chat in the appropriate place. And then that person, and all are very accessible people, very happy to help make connections for you, and can bring in the right people at the state.

Because it can be a little bit overwhelming to identify in some states the Medicaid agency who is the best point of contact to start developing partnerships. So I think MCOG could be a great resource for you.

RACHEL POST: Thank you, Jean. Another question-- Oh, go ahead, Martha.

MARTHA EGAN: I think, I mean, Jean mentioned it briefly, but the only other thing that I would add on is I'd certainly encourage folks to look at the state Medicaid websites. There's always, generally, a lot of information there. And it may be a good idea to begin wading through what is available to you on the actual state's own Medicaid website.

RACHEL POST: Great, thank you. Another question that's a little bit similar. Is there an easily accessible resource that shows which states are doing what services for social determinants of health?

JEAN CLOSE: OK, I'll start off. Again, I think that Medicaid.gov website, that has the benefits section, would be a useful resource to get that. And also, matching that up with the State Health Official's letter that's cited on the slide would be, I think, a great and worthwhile exercise, to match those two sources up together.

MARTHA EGAN: I would just add on, the State Health Official's letter, it does include state examples. So you get a really nice flavor of what states are doing around social determinants of health under the Medicaid program.

RACHEL POST: Great, thank you. I'm just going to check in with Alicia to see, Alicia, are there other questions that have come through that we'd like to ask?

ALICIA WOODSBY: Yeah, we did have another question for CMS. It reads, for increased ARPA FMAP for HCBS, a lot of acronyms there, for increased American Rescue Plan Act, the Federal Matching Assistance Program for Home and Community-Based Services, wasn't the initial spending plan due in June from the state Medicaid agency? Are there any other benefits in this space for states who didn't apply by the deadline? I think that was for Jen.

JENNIFER BOWDOIN: Hi, everyone, this is Jen Bowdoin. So I can answer that question. So we actually allowed states to request a 30-day extension. A number of states did request that, and all states at this point have submitted, all states plus D.C., Washington D.C., have submitted spending plans.

A number of those plans are actually still under review with CMS. But I would encourage states to look at the website of your state Medicaid agency. A number of states have posted their spending plans on their website, and CMS will be, in the future, posting summary information about what is included in state spending plans. Although we don't have that information available on Medicaid.gov just yet.

RACHEL POST: Thank you, Jen. Alicia, other questions?

ALICIA WOODSBY: We do have some questions related to some guidance or best practices around how to engage at a more local level, at a community level. Some questions around ways to bring PHAs to the table, and engage them in working collaboratively with Medicaid providers. And also, in a scenario where there's multiple managed care plans, how do you work with multiple managed care plans at one time, and try to engage and coordinate with the housing system?

RACHEL POST: Great question. Is there anyone from HUD who would like to take the first part of that question, about how PHAs can engage? I'm sorry, Alicia, the first part of the question, again, was they can engage with providers?

ALICIA WOODSBY: How to bring PHAs to the table to work collaboratively with the Medicaid providers. And that one was specifically for clients who may not be involved with Coordinated Entry. They were thinking of justice involved clients.

RACHEL POST: So, one practice that I've seen in some communities with regards to justice involved individuals and PHAs is that working with a PHA, sitting down and having a discussion about the logistics of the level of service that's offered to an individual, and ensuring that there will be supportive services staff that are available to work with an individual intensively, if needed.

And PHAs sometimes, as many of know, feel like they haven't always been able to rely on service providers to respond when things go south, particularly if something's happening in the middle of the night, or on a weekend, and they're not able to reach agency staff.

And so, I've actually seen, in some communities, MOUs between service providers serving folks through re-entry programming and PHAs, that really outlines the level of service that will be offered, the hours in which those services are available, the amount of time that will not be gone over before somebody is able to respond.

But if other folks have any additional thoughts on this, I'd welcome them to chime in.

DANIELLE GARCIA: Hi, this is Danielle Garcia. I will say that that definitely is a challenge that we recognize. We have a working group in place where we are continuing our relationship and our collaboration with our partners over at HHS, hence the reason why we're hosting this wonderful webinar series for our clients, for PHAs, and other constituents, just to really understand how to marry the two services when it comes to health and housing.

So we are working actively to build that relationship at the local level, and recognizing how important that is. But right now, I would say if anybody has questions, definitely contact your local housing authority. You could even reach out to our local field office, and we can try to bridge that gap between partnerships with involving the local HHS at the state level.

RACHEL POST: That's great. Thank you, Danielle. And I wonder if the same would be true of working with multiple managed care organizations, if that's something that a local field office, and perhaps the HUD Continuum of Care governing body, can help facilitate partnerships when there's more than one managed care organization. Or possibly, our speakers from CMS may have some thoughts on that part of the question.

[OVERLAPPING VOICES]

MARTHA EGAN: This is Martha. One thing that popped in my mind is if you're seeking information around home and community-based services, at a very individual level in the community, you're trying to identify providers in that space, to reach out to your Aging and Disability Resource Centers, ADRCs, for your AAAs, your area agencies on aging. Many of those organizations have what were called no wrong door systems, where you can go there to get information on long-term services and supports and home and community-based services. I don't know if that directly is really going to facilitate or foster those partnerships that are needed, but certainly as a place to go to identify what kind of resources, and potentially who are the providers that are providing some of those resources, might be available to you through those networks.

RACHEL POST: Thank you, Martha. Another question we have is, how does a person know if they are eligible for the Money Follows the Person program?

MARTHA EGAN: I'll jump in real quick. So the Money Follows the Person program, there are some eligibility criteria for the program. I'll start with there are 33 states and the District of Columbia that are participating in the program, and you can go on to the Medicaid.gov MFP website to identify the states that are participating in the program. And in order for an individual to be eligible for the program, they do have to be an individual who is residing in a medical institution, such as a skilled nursing facility, for a minimum of 60 days.

And they do need to have what we would call a nursing home level of care to be eligible for home and community-based services in the community. And they, through the MFP demonstration program, there will be outreach support if somebody is in an institution, and they do identify that they are interested in returning to the community, that's kind of where they would start. Right? In identifying that need inside an institution, and make that determination on whether an individual is eligible for the MFP program. Those are some minimum criteria that are out there for MFP eligibility.

RACHEL POST: Thank you. I have a question that asks, can presenters talk about the ideas for other routes for services for non-disabled homeless people needing tenancy support, if a state does not have-- Let's see, I'm sorry, my little screen here isn't really--

Alicia, I'm going to ask if you could finish reading that question. You're on mute. Thank you.

ALICIA WOODSBY: Sure. Let me just scroll back up.

Can presenters talk about ideas for other routes for services for non-disabled people experiencing homelessness that need tenancy supports? If a state doesn't have many of the optional services in their approved plan, what do they do? This person thinking specifically about Medicaid covered peer services, or any other form of outreach in-home visitation.

JEAN CLOSE: I could start off, and then Martha or Jen can add to what I have to say on that. So individuals who are homeless could be Medicaid eligible. So I think that the first step is providing assistance, or identifying an entity that really can help someone become Medicaid eligible.

One resource, and then others on the phone may also suggest where that assistance may come from, but Federally Qualified Health Centers many times have a great capacity for negotiating and dealing with eligibility concerns and issues. So that homelessness should not be a barrier to accessing Medicaid eligibility.

So that opens the door, of course, and then an individual who has a medical need that rises to the level of either the home and community-based services level of care, when an institution would be able to qualify for the state's 1915(c) waiver programs. I've mentioned a wide range of services.

That varies by state, not all states have a comprehensive menu of services within the program. So keep that in mind. But that level of care would be necessary. The 1915(i) program is the state plan HCBS program, is less stringent in level of care and requirements. It doesn't actually have a facility level of care requirement. But there's other requirements. So that's another possibility, again, if a state furnishes 1915(i) state plan HCBS services.

So that said, but again, if someone is Medicaid eligible, and in states that cover the adult group, there is a full range of Medicaid services. You'll notice the list of mandatory services. They would be able to receive those services, and whatever is in the plan that the state offers for the adult group, as well. But others, Martha and Jen, do you have anything else to add?

JENNIFER BOWDOIN: The only thing I would add is that states can, under section 9817, with the additional 10% in the Federal Medical Assistance Percentage, that additional funding that they're getting, the states could use that money to expand the services that are available, as well as to cover additional services for additional populations. And so, I would really encourage folks to reach out to their state Medicaid agency, and talk to them about the things that they think are important for Medicaid beneficiaries, or individuals who could potentially qualify for Medicaid.

We are encouraging states very strongly to engage with stakeholders, in terms of the types of activities that are in their plans. And as Martha mentioned, a lot of states are still in the planning phases. So I think there's lots of opportunity for states to make adjustments to what's in their plans, to add additional activities, to modify the things that they've requested. And so I think there's lots of opportunity for stakeholders to reach out to the states, and to talk about what they think is important.

RACHEL POST: Thank you so much, Jean and Jen. Alicia, I see that we have a little bit less than 2 minutes left. Are there any short, final questions we'd like to ask of our panelists?

ALICIA WOODSBY: Maybe as a last question, we did have one for CMS that was-- I'm just trying to scroll back down to it-- related to respite. Why is this not letting me-- One second. Can you speak to respite care for caregivers who are also IHSS providers for IHSS recipient living in the same.

JEAN CLOSE: Well, I think there's two questions about respite care. And for anyone who has a family member with dementia or disability can realize how important it is for family caregivers to have respite, so they're able to be strong, to carry on with their family caregiving roles. And respite care is available for the individuals when they're enrolled in a state plan or a 1915(c) waiver program. So that's really an important option or service.

Now, as far as the particulars related to IHSS, I'm really not familiar with the parameters of that program. So I'd have to defer on that answer.

RACHEL POST: All right. Well, thank you. Thanks so much to our panelists today from CMS, and to HUD for hosting this webinar. We are at time.

We appreciate all the questions that have come in, and I know that the public housing agencies and CoCs do know how to submit questions via the HUD AAQ. So if you have additional questions, please don't hesitate to submit them there. Reach out to your points of contact.

And thanks, everyone. We hope that you have a safe and productive rest of your week. Thank you so much.