BRIEF | January 2016

CHCS Center for Health Care Strategies, Inc.

Supportive Housing for Chronically Homeless Medicaid Enrollees: State Strategies

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IN BRIEF

Nearly all individuals experiencing chronic homelessness could be eligible for Medicaid in states pursuing Medicaid expansion under the Affordable Care Act. Given that many of these individuals are at risk for high health care utilization and costs, state and federal policymakers and budget officials are increasingly interested in cost-effective approaches to meet the needs of this population. In July 2015, the Center for Health Care Strategies, with support from the California HealthCare Foundation, the Conrad N. Hilton Foundation, and the New York State Health Foundation, convened state and federal officials along with research and policy experts to identify strategies for expanding access to housing and related services for Medicaid beneficiaries who are chronically homeless. This brief highlights key opportunities for Medicaid programs to better address the housing needs of this high-need, high-cost population.

Individuals experiencing chronic homelessness[1] often also struggle with serious mental illness, substance use disorders, physical and mental disabilities, and chronic medical conditions. They are, therefore, more likely to use acute health services.[2,3] This combination of diagnoses and utilization equates to high annual health care expenditures for homeless individuals, with one expert estimating more than $26,000 in total annual costs per Medicaid enrollee experiencing homelessness compared to $5,790 on average.[4,5]

Given this linkage between housing instability and avoidable health care utilization and costs, policymakers are increasingly focused on more cost-effective opportunities to address the housing and health care needs of chronically homeless individuals. These opportunities are particularly robust in states that have expanded Medicaid eligibility under the Affordable Care Act (ACA), where most chronically homeless individuals are eligible for Medicaid. In these states and elsewhere, there is keen interest in expanding access to permanent supportive housing models, particularly given their demonstrated potential for health care cost savings through reduced hospitalization and emergency department (ED) use.[6]

Medicaid prohibits paying directly for housing; however, an informational bulletin in June 2015 from the Center for Medicaid and CHIP Services (CMCS) details circumstances under which

Made possible through the California HealthCare Foundation, the Conrad N. Hilton Foundation, and the New York State Health Foundation.

Medicaid can fund housing-related services.[7] States are using various approaches to address homelessness in their Medicaid populations, including leveraging flexibility within their managed care plans to cover housing-related services, funding housing-based supports through 1115 waivers and Section 2703 health homes, and identifying alternative financing sources such as Pay for Success contracts.

In July 2015, the Center for Health Care Strategies (CHCS) convened state Medicaid officials; federal policymakers from the Department of Health and Human Services (HHS), the Department of Housing and Urban Development (HUD), the Office of Management and Budget (OMB), and the United States Interagency Council on Homelessness; and experts in the fields of managed care, housing, and homelessness to address this issue. The discussion focused on strategies for increasing access to housing and related supports for Medicaid beneficiaries who are chronically homeless. Drawing on insights from the session, this brief highlights key opportunities for Medicaid programs to better address the housing needs of these individuals.

Opportunities and Considerations

1. Develop alternative metrics for identifying homeless individuals in existing Medicaid and state data sources.

Existing Medicaid data do not consistently capture information on homelessness in a comprehensive or straightforward way. Some states are exploring how to integrate health care claims and utilization data with Homeless Management Information System (HMIS) databases. Shelters and other entities that receive HUD funding use HMIS to capture information on individuals interacting with these systems. These databases, however, are typically administered regionally and not statewide, so one challenge for many states will be linking to multiple regional HMIS databases to identify who among their Medicaid-enrolled population could benefit from housing-related interventions. Another challenge is that HMIS databases do not capture information on all individuals experiencing homelessness, e.g., those who do not frequent shelters.

States may also consider developing alternative indicators or algorithms to help identify individuals at risk for residential instability. For example, in Washington State, Medicaid officials have leveraged an alternative state data source for identifying homelessness or risk of homelessness among the Medicaid population. Specifically, individuals who apply for food assistance are asked what their living arrangements are – at the point of both application and recertification. This information is recorded in both the Supplemental Nutrition Assistance Program (SNAP) and the Temporary Assistance for Needy Families (TANF) databases, which the state's Department of Social and Health Services has linked at an individual beneficiary level to Medicaid program data. Internal analyses indicate that these data have significantly increased Washington's ability to identify beneficiaries experiencing or at risk of homelessness.

Tips

- Confirm that your state's applications ask about each beneficiary's living situation.
- Link state Medicaid data with existing HMIS data reported to HUD.
- Encourage providers to use the new ICD-10 code for homelessness.

Additional indicators that could help states identify individuals at risk for homelessness include identifying when a shelter or other public building is listed as a beneficiary's home address in eligibility files, or when reported residence is in areas and/or zip codes associated with higher rates of homelessness. Additionally, the new International Classification of Diseases, 10th revision (ICD-10) claims code for homelessness could offer an additional avenue for states to identify individuals who are homeless. In order for this measure to be used successfully, however, providers need to be aware of it and encouraged to record it on claims.

2. Design incentives for health plans to invest in housing-related services.

Medicaid managed care organizations (MCOs) have the flexibility within their capitation rates to add services beyond the basic Medicaid benefit package to address specific beneficiary needs and better manage services. With the ACA's extension of eligibility to high-cost homeless members in states that have expanded Medicaid, MCOs in these states have new financial incentives to seek ways to better manage costs for this population. However, these incentives are time-limited, given that current Medicaid managed care rate-setting methodologies do not reward MCOs for making investments in housing over the long-term. Specifically: (1) investments made in non-Medicaid covered services like housing are not included in the expenditures used to set rates in future periods; and (2) reduced rates of hospitalizations and ED visits that may result from housing interventions further lower the cost basis used to set future rates. In addition, enrollment churn creates additional disincentives for a plan weighing the risk of investing in housing, because the member may leave that plan before savings linked to the housing investment are realized. Thus, states should consider engaging with federal partners to improve long-term health plan incentives for investments in non-Medicaid reimbursable interventions such as housing that appear to be cost-effective. For example, Medicaid programs could potentially share savings with health plans to maintain the financial returns resulting from increased access to housing for high-risk members.

Tips

- Talk with MCOs about the value-added services that could be provided to members under the flexibility of their capitation payment – including what they might already be doing.
- Consider pilot opportunities to test alternative incentive arrangements with MCOs.

California's newly approved 1115 waiver – Medi-Cal 2020 – aims to address the flexibility of services and financing relating to the MCOs. Through the state's Whole Person Care Pilot program, which will provide integrated care for high-risk, vulnerable populations, MCOs and counties could form regional housing partnerships to receive incentive or shared savings payments for participation.[8] These voluntary partnerships could then establish an optional savings pool to assist plans and counties in funding interim housing, subsidized housing units, or long-term rental subsidies and assistance.

3. Target limited resources to a specific subset of the homeless population.

Limited affordable housing stock and current long wait lists for vouchers demonstrate an imbalance in supply and demand for housing in regions across the country.[9] States are appropriately wary about pursuing efforts to fund housing-related services if there is no guarantee that housing itself will be available once eligible individuals are identified. Therefore, in most cases it is critical for states to identify a high-priority subset of the population on whom to focus limited housing resources. Potential subsets might include: high-need, high-cost individuals; individuals at risk of institutionalization; or individuals who are frequent utilizers of both the health care and corrections systems. One of these subsets could be the focus of a joint HHS/HUD waiver or pilot project in which a discrete number of housing units are identified and reserved for something akin to assisted living for these individuals.

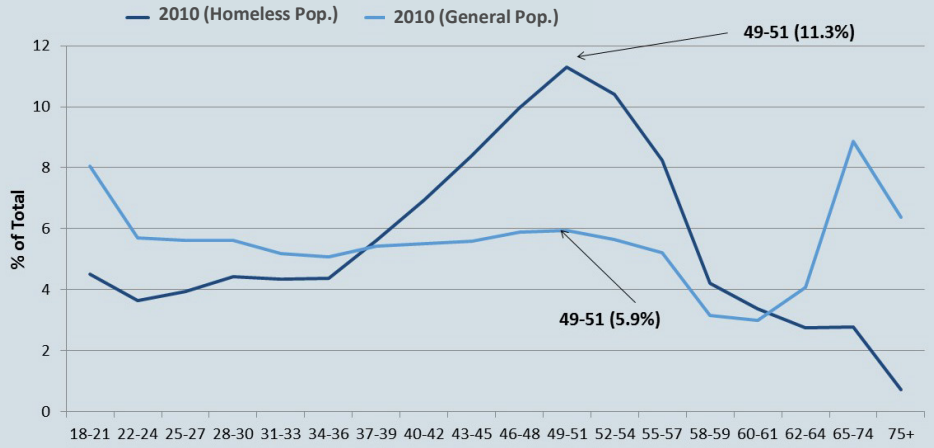
Tips

- Conduct data analysis and engage internal and external stakeholders to identify priority population subsets for targeted housing interventions.
- Explore collaborations with state and local corrections partners to identify high users of both health care and criminal justice systems.
- Explore opportunities to use HHS and/or HUD demonstration authority to pilot a targeted intervention.

HIGH-NEED, HIGH-COST SUBSET TO TARGET: HOMELESS ADULTS AGE 55+

Adding to the picture of homelessness is a significant concentration by age. Although adults ages 55 and older account for less than six percent of the overall U.S. population, they represent more than 11 percent of chronically homeless individuals nationally.[10] As health care spending among the chronically homeless population has been shown to increase by age, these individuals, and those providing or paying for their health care, may benefit the most from targeted housing interventions.

Highest Rates of Homelessness are in Older Adults



Source: U.S. Census Bureau Decennial Census Special Tabulation

4. Explore alternative financing strategies for housing.

Another potential strategy for expanding housing resources for high-need subpopulations is to use alternative financing options such as Pay for Success (PFS), an emerging funding mechanism for social reform projects. The model uses private investor funds to support specific services that may be otherwise difficult to finance. Repayment occurs only if the program achieves agreed-upon metrics, which are associated with quantifiable cost-savings. Given the evidence base supporting the cost savings potential of supportive housing for targeted, high-need populations, it is particularly well suited for a PFS approach.[11] For example, HUD and the Department of Justice recently announced a joint PFS demonstration to fund supportive housing projects aimed at preventing returns to homelessness and reducing criminal justice system recidivism.[12]

Tips

- Ask your Governor's office about the state's involvement in PFS initiatives to learn about their feasibility and potential local partners.
- Connect with national organizations experienced with the Pay-for-Success model to provide funding guidance.

In Massachusetts, the state launched a supportive housing PFS initiative led by the Massachusetts Housing and Shelter Alliance to provide 800 homeless individuals with housing, job training, and medical care. The initiative began in December 2014 with 50 dedicated housing units and a commitment to scale up to 500 units over the first two years. During the initiative's planning phase, the Medicaid agency played a key role in developing the PFS contract and in engaging with MCOs. The state is committing to ongoing funding for housing through dedicated housing vouchers.[13]

5. Increase coordination and partnerships with other agencies.

Efforts to provide housing and related services for individuals with complex medical, behavioral health, and social needs must involve multiple funding streams and associated agency involvement. Aligning policy goals and program efforts across silos and establishing relationships that will support effective collaboration and braiding or blending of funds requires concerted effort. Given this complexity, it is still uncommon to see sustained partnerships across agencies (e.g., Medicaid, state and local behavioral health agencies, the state housing finance authority, the local public housing authority, the HUD field office, and the Governor's office). Looking ahead, coordinating these funding streams will require greater investment in the development and sustainability of cross-agency partnerships.

Tips

- Ask if your state has an existing housing workgroup or other cross-agency consortium that could expand to include housing issues. If not, your state's Medicaid agency could spearhead such a workgroup.
- Review the CMS informational bulletin to determine what state authority your Medicaid program may already have in place to provide supportive housing services.

In New York, the affordable housing workgroup of the Medicaid Redesign Team (MRT) is a rare model of such a partnership.[14] Co-chaired by Medicaid, a collective of state agencies and external stakeholders developed a plan to increase access to housing and related services for targeted Medicaid beneficiaries. This included capital funding to expand access to housing units for high-cost Medicaid populations and home modifications to enable individuals to transition or remain in their homes. It also included rental subsidies, tenancy advocacy, and, for beneficiaries at risk

for becoming homeless, it supported counseling, case management, job development, and clinical supervision. To date New York has invested $388 million in state-only dollars for these supportive housing-related services.[15]

Medicaid programs should also consider the new federal options to pay for housing-related supportive services, thus freeing up other state funds allocated to non-Medicaid agencies. In turn, those state funds could be used for rent and capital development. Per the CMCS Informational Bulletin released in June 2015,[16] there are various supportive housing-related services that Medicaid is already authorized to cover that could result in a better alignment of "who pays for what" for the homeless population. States may need technical assistance to identify, understand, and implement the options that make the most sense in their environment.

6. Acknowledge and begin closing the "language barrier" between the health care and housing worlds.

Those in the health care and the housing worlds use jargon specific to their respective fields, especially as it relates to funding and federal authority. There is considerable confusion given that some terms have different meanings for health care and housing stakeholders (for example "supportive services" and "continuum of care," see *Clarifying Jargon* box on page 7). When bringing stakeholders together, the state agency or agencies convening a discussion should be mindful of these language barriers and make efforts to increase understanding across fields. One simple step is to include a team member who can serve in a translator role in mixed stakeholder meetings. Glossaries and primers can be helpful resources and informal "get to you know you" sessions at the provider level can help initiate relationships across sectors.

Tips

- Provide an acronym list and/or jargon glossary at meetings with stakeholders across the spectrum of health, housing, homelessness, and criminal justice.
- Take time to understand the structure and mechanics of fields outside of your daily expertise.

The Bronx Health and Housing Consortium started in 2011 and gained momentum with the implementation of health homes in New York as providers sought a mechanism to increase communication and collaboration across the housing and health care arenas. The Consortium is comprised of over 40 organizations, bringing together representatives from health, housing, and social service sectors as well as related government agencies. The shared goal is to improve health outcomes for their clients. Participants believe that fostering provider understanding across health care and housing is the key to successful intensive care management for targeted high-need, high-cost clients in the Bronx.

CLARIFYING THE JARGON

Supportive Services can include many different types of services depending on the perspective of the user and the context of the term. In Medicaid, it typically includes a broad range of services such as care coordination, employment support, and environmental modifications that relate to long-term services and supports. Through a housing lens, "supportive services" focuses more specifically on those relating to securing and maintaining housing. While there can be a great deal of overlap in actual services (e.g., assessment and care plan development; independent living skills training; etc.), a general reference to "supportive services" often causes more confusion than clarity until additional specificity or context is applied.

Continuum of Care, a phrase used often in Medicaid and health care in general, refers to an "integrated system of care that guides and tracks patients over time through a comprehensive array of health and health-related services spanning all levels of intensity of care."[17] In the housing world, continuum of care generally refers to a regional planning body that coordinates the housing and service funding for individuals experiencing homelessness. More formally, according to HUD, a Continuum of Care or CoC is "a community plan to organize and deliver housing and services to meet the specific needs of people who are homeless as they move to stable housing and maximize self-sufficiency. It includes action steps to end homelessness and prevent a return to homelessness."[18]

7. Increase beneficiary access to housing resource experts.

State Medicaid agencies often have multiple programs that provide various types of care coordination based on member's eligibility status, health needs, managed care enrollment, and county of residence. Thus, it is common for beneficiaries with complex needs to have multiple care coordinators, most of whom have little or no supportive housing expertise. States and their delivery system partners should consider increasing beneficiary access to housing resource experts, individuals who are adept at navigating local housing resources and have experience addressing the needs of individuals experiencing homelessness. This can be done by embedding housing specialists in existing care management programs, or marrying care management programs with supportive housing care management or other resources in the community.

Tips

- Map out existing care coordination opportunities in your state with the goal of understanding which populations of beneficiaries are eligible for each, as well as who might need but currently lack access to care coordinators.
- To learn more about care coordination through Medicaid health homes, visit CMS' Health Home Information Resource Center.

One potential vehicle for providing this overall coordination – thus decreasing the opportunity for miscommunication between multiple care coordinators – is through Medicaid health homes. Given the high prevalence of mental health and substance abuse conditions among chronically homeless populations and the linkage between health home services and supportive housing services, health homes may be among the most effective tools available to help meet the needs of people who are homeless. In California's proposed health home program design, the state is considering requiring a housing navigator who will partner with the care manager and beneficiary to navigate the housing system.

8. Engage advocacy efforts at the federal level.

Ultimately, strategies to increase access to housing depend on the availability of permanent supportive housing stock. Existing data and studies point to significant shortages of affordable supportive housing, particularly in communities with higher incidence of chronic homelessness.[19] States and stakeholders may want to focus on raising policymaker awareness regarding the need for housing resources for at-risk populations.

Tips

- Learn about the magnitude of the housing deficit in your state by reaching out to the state housing finance authority.
- Help raise policymaker awareness of the need for housing resources for specific, targeted, at-risk populations.

In recent years, grassroots and formal advocacy efforts have had a significant impact on addressing needs of subsets of homeless individuals, especially veterans and youth. In 2010, the White House and Veterans Administration launched the End Veteran Homelessness initiative, an unprecedented effort to find and maintain housing for veterans with the clear-cut goal of ending homelessness for these individuals by the end of 2015. To date, the initiative has made great strides by decreasing the number of veterans who are homeless by 33 percent since 2010.[20] Additional funding support has been garnered for homeless youth through the prominent backing provided by celebrities and well-known advocates.[21] Similar types of advocacy and funding support would be beneficial in improving health and social service access for homeless individuals with chronic illnesses.

Conclusion

Without stable housing, individuals experiencing homelessness, especially those with chronic medical and behavioral health needs, will continue to need avoidable and expensive health care services. In many cases, addressing their most pressing basic need – housing – would create the stability they need to address their health conditions. Recognizing that housing stability is a core social determinant of health, states may want to consider the strategies outlined in this brief to use Medicaid funding for essential housing-related services.

SMALL GROUP CONSULTATION PARTICIPANTS

Thank you to the following individuals who joined the authors of this paper to provide guidance and expertise at CHCS' July 2015 small group consultation:

Julie E. Bluhm, Hennepin County, Minnesota; **Thomas H. Byrne**, Boston University; **Richard S. Cho,** United States Interagency Council on Homelessness; **Dennis P. Culhane,** University of Pennsylvania; **Anne Fletcher,** U.S. Department of Housing and Urban Development; **Richard G. Frank,** U.S. Department of Health and Human Services; **Hannah Katch**, California Department of Health Care Services; **David C. Mancuso,** Washington State Department of Social and Health Services; **Philip F. Mangano,** American Round Table to Abolish Homelessness; **Andy McMahon,** CSH; **Elizabeth J. Misa,** New York State Department of Health; **Bill Pitkin**, Conrad N. Hilton Foundation; **Maria Raven,** UCSF School of Medicine; **Nan P. Roman**, National Alliance to End Homelessness; **Emily Rosenoff,** U.S. Department of Health and Human Services; **David Sandman,** New York State Health Foundation; **Carrie Schuettpelz**, U.S. Department of Housing and Urban Development; **Michael R. Smith,** Center for Medicaid and CHIP Services; **Jessica L. Sun,** U.S. Office of Management and Budget; **Scott Taberner,** Office of MassHealth; **Catherine Teare,** California HealthCare Foundation; and **Stefanie Zier,** Washington State Healthcare Authority.

This work was made possible by the California HealthCare Foundation, the Conrad N. Hilton Foundation and the New York State Health Foundation. The views presented here are those of the authors and not necessarily those of the funders.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit health policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

ENDNOTES

[1] The US Department of Housing and Urban Development defines chronic homelessness as "continuously homeless for a. year or more or at least four episodes of homelessness in the past three years;" for more information, visit: https://www.hudexchange.info/homelessness-assistance/resources-for-chronic-homelessness/.

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[13] To learn more about the Massachusetts Alliance for Supportive Housing pay-for-success initiative, visit: http://www.mhsa.net/PFS.

[14] For more information about New York's Medicaid Redesign Team Affordable Housing Workgroup, visit https://www.health.ny.gov/health_care/medicaid/redesign/affordable_housing_workgroup.htm.

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