

# Medicaid-Financed Services in Supportive Housing for High-Need Homeless Beneficiaries: The Business Case

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For many individuals with complex chronic health conditions, homelessness and housing instability can be the most significant impediments to health care access, often resulting in excessive utilization of expensive inpatient and crisis services. For these individuals, supportive housing offers an evidence-based solution to improving health outcomes while reducing costs.

By providing stable affordable housing coupled with “high touch” supports that connect people with chronic health challenges to a network of comprehensive primary and behavioral health services, supportive housing can help improve health, increase survival rates, foster mental health recovery, and reduce alcohol and drug use among formerly homeless individuals. To help states prepare for Medicaid expansion and anticipate the needs of this high-need population subset, this brief:

1. Outlines the potential benefits of care management linked to affordable housing;
2. Details the business case for using Medicaid to finance supportive housing-based services from the viewpoint of Medicaid as well as the supportive housing industry sector;
3. Highlights potential Medicaid authorities that states can use to fund supportive housing-based services; and
4. Raises considerations for policymakers to address in designing strategies that use Medicaid resources to provide supportive housing-based services for people who are homeless.

## **Opportunities for Supportive Housing in Health Reform**

Although supportive housing has long been a beneficial approach for individuals with chronic illnesses (and resulting high costs) who are homeless, the Affordable Care Act (ACA) increases opportunities for states and communities to take advantage of supportive housing’s benefits:

1. Nearly all homeless chronically ill adults will be Medicaid-eligible beginning in 2014.
2. The ACA’s creation of a new state plan option for health home services gives explicit priority to coordinating care for beneficiaries with mental illnesses, substance use disorders, and other chronic conditions that are often found among tenants of supportive housing.

### IN BRIEF

Medicaid expansion under the Affordable Care Act (ACA) will provide new insurance coverage to more individuals who are homeless. States could consider leveraging various Medicaid service options, such as health homes, to provide these new beneficiaries with care management services linked to supportive housing.

Medicaid-financed care management in supportive housing for high-risk homeless Medicaid beneficiaries could yield a significant ROI from reduced hospitalizations and emergency department use. Growth in Medicaid managed care for these individuals, particularly after 2014, will expand opportunities to capitalize on care management linked to supportive housing with the prospect for sharing associated savings across providers, health plans, and states.

This brief outlines the rationale for states to consider designing Medicaid-financed, supportive housing-based care management services to improve care for at-risk beneficiaries while lowering costs associated with avoidable hospitalizations and other crisis services.

## Defining Care Management Linked to Affordable Housing

Care and case management terms have specific connotations based on the setting in which they are used (e.g., Medicaid, supportive housing, behavioral health). Throughout this paper, we refer to *care management linked to affordable housing*. In so doing, we seek to distinguish the services offered within supportive housing from other forms of care and case management. Housing-based care management services are: (a) provided in and around the beneficiary's home to make the services as accessible as possible; and (b) focused on ensuring housing stability, recognizing housing's role as an essential platform for recovery and improved health.

These changes may compel states to consider developing a Medicaid-focused supportive housing strategy for individuals experiencing, or at-risk of, homelessness. States can consider using supportive housing to bend the Medicaid cost curve, namely, by improving outcomes and reducing costs among homeless or precariously housed high-cost Medicaid beneficiaries. In turn, with Medicaid becoming a more viable means of paying for care management linked to affordable housing, states can consider using Medicaid to leverage investments from affordable housing sectors to cover the capital and operating costs for supportive housing.

## Background

Prior to the ACA, many chronically homeless adults, including those residing in supportive housing, were not eligible for Medicaid. Beginning in 2014, nearly all homeless persons will, by virtue of their incomes, be eligible for Medicaid. Given the anticipated health needs of the homeless subset of the expansion population, states have a compelling opportunity to invest in care management and other well-targeted services that have the potential to divert the need for more expensive utilization down the road.

Across Medicaid, roughly five percent of beneficiaries account for 50 percent of program costs. The high prevalence of mental illness, substance abuse, and co-occurring physical disorders in the

chronically homeless population suggests that many of these individuals, once folded into state Medicaid programs, could become part of this cohort driving Medicaid costs. Managing care for these individuals, therefore, will be critical to efforts to control overall program costs.

At the same time, the ACA provides additional resources and program authorities that can support innovations in serving this population. In most states, the ACA will initially provide 100 percent federal funding for individuals with incomes under 138 percent of the federal poverty level and not currently eligible for Medicaid, including people who are homeless. Although this level of support will decline over five years to a 90 percent federal match, it provides states with a valuable window for improved chronic care management prior to paying a state share of the costs. In addition, the ACA also creates a new state plan option that provides 90 percent federal match for eight quarters for the establishment of "health homes." This new service option is available for people with serious mental illness or multiple chronic conditions, including mental health and substance abuse disorders, which are highly prevalent among the chronically homeless.

## Demographics and Health Care Needs of the Homeless

According to the U.S. Department of Housing and Urban Development's 2010 Annual Homeless Assessment Report (AHAR) to Congress, approximately 1.2 million people across the nation were homeless and used emergency shelters or transitional housing for at least one night during 2010.<sup>1</sup> Roughly two-thirds of these were single adults and approximately 10 percent were chronically or long-term homeless.

Since chronic physical and mental health conditions may contribute to a person becoming homeless, it is no surprise that there is a higher prevalence of these

conditions among people in emergency shelters, living on the street or cycling in and out of institutional settings. Homeless adults, particularly those who are chronically or long-term homeless, are far more likely to suffer from chronic medical conditions, such as HIV/AIDS, hypertension and diabetes and to suffer complications from their illness due to lack of housing stability and regular, uninterrupted treatment.<sup>2</sup> In 2010, an estimated 46 percent of adults in housing shelters had a chronic substance abuse problem and/or a severe mental illness. For those in supportive housing, 82 percent have a mental or physical health disability, more than half had a substance abuse and/or serious mental health condition, and 6.4 percent had HIV/AIDS.<sup>3</sup> Mortality rates among homeless adults are three or more times greater than that of the general population.<sup>4</sup>

Due to the high incidence of chronic illness and lack of regular care, health care costs, particularly crisis-related, for individuals who are homeless are excessive. The Boston Health Care for the Homeless program, which followed a cohort of 119 homeless adults, found that these individuals accounted for 18,384 emergency department (ED) visits and 871 medical hospitalizations over a five-year period with average annual health care costs of \$28,436.<sup>5</sup> In the California Frequent Users of Health Services Initiative, which sought to link high ED users with care management supports, approximately 45 percent of the individuals who met the criteria of frequent users were also homeless individuals.<sup>6</sup> And a New York study identifying risks for hospital admissions found that individuals who were high users of hospital services (>\$39,000 on average) and at risk for future admissions had a high prevalence of homelessness – 60 percent reported being homeless or in precarious housing situations with family or friend.<sup>7</sup> These individuals were also much more likely to name the ED as their usual source of care and to have a hospital stay related to substance abuse or mental illness.

Estimates on the percentage of people living in homelessness who are eligible for Medicaid vary widely depending on state eligibility policies; however, in most states the Medicaid program does not currently cover homeless single adults. For example, HUD's AHAR<sup>8</sup> reports on low initial eligibility rates (10-15 percent) among homeless individuals for Supplemental Security Income (SSI), which would also make them categorically eligible for Medicaid. Most states have not expanded coverage to single adults not eligible for SSI. Only 22 percent of clients receiving services through the Health Resources and Services Administration's Healthcare for the Homeless program are enrolled in Medicaid.<sup>9</sup> Application requirements for Medicaid, such as proof of citizenship, also pose a barrier to enrollment in the Medicaid program for chronically homeless individuals. In addition, service providers are often reluctant to make a shift to adopting Medicaid-coverable services and billing practices.

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Mortality rates among homeless adults are three or more times greater than that of the general population.

### Supportive Housing: Review of Evidence and Outcomes

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Supportive housing linked with care management connects stable, affordable housing with a team of clinical and support staff to help individuals gain access to primary and behavioral health care services. Research from programs across the country<sup>10</sup> has demonstrated that linking care management to supportive housing can dramatically improve health outcomes:

- A Denver study<sup>11</sup> found 50 percent of tenants in supportive housing experienced improved health status, 43 percent had better mental health outcomes, and 15 percent reduced substance use;
- A Seattle<sup>12</sup> study found 30 percent reduction in alcohol use among chronic alcohol users in supportive housing;
- Both a San Francisco<sup>13</sup> and a Chicago<sup>14</sup> supportive housing project had significantly higher survival rates for

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The studies of supportive housing programs for the chronically homeless report an 87 percent decrease in use of detox services and a 38 percent decrease in psychiatric admissions.

individuals with HIV/AIDS compared to a control group.

In addition to improved health outcomes, recent research on supportive housing programs demonstrates that care management linked to affordable housing can impact health care utilization and overall program costs. These studies document that supportive housing for the chronically homeless can result in significant outcomes:

- **Reductions in ED use.** The Chicago Housing for Health Partnership program found that an intervention group of roughly 200 homeless individuals who were provided housing and case management services used 24 percent less ED services than a randomized control group over an 18-month period.<sup>15</sup>
- **Decreases in inpatient admissions and hospital days.** The same Chicago study saw 29 percent fewer hospital admissions and hospital days for the intervention group compared to the control group. The California Frequent User Initiative reported a 27 percent reduction in hospital admissions and inpatient days for homeless clients connected to housing and case management.<sup>16</sup>
- **Reductions in detox utilization and psychiatric inpatient admissions.** The studies of supportive housing programs report an 87 percent decrease in use of detox services (Seattle East Lake project<sup>17</sup>) and a 38 percent decrease in psychiatric admissions (Maine).<sup>18</sup>
- **Reductions in Medicaid costs.** A Massachusetts pilot showed that these decreases in acute care utilization translated into real savings in Medicaid costs. Comparing actual Medicaid costs pre- and one-year post housing, the study found a 67 percent decrease in average Medicaid costs (\$26,124 to \$8,499).<sup>19</sup> The Seattle East Lake

project likewise reported 41 percent lower Medicaid costs for residents after one year of supportive housing.

Linking care management to supportive housing and the resulting improvements in health outcomes also offers additional advantages from a broader state government perspective. In the Seattle East Lake supportive housing project, the study population's burden on many public systems was reduced substantially, although not easily translated to overall public expenditures. Using jail as an example, public costs would not decrease noticeably unless enough incarcerations were avoided to justify decreasing numbers of jail personnel, etc. Savings were generated from fewer units of jail bookings and incarceration days for the study population.

## Business Case 1: A Medicaid Lens

States are increasingly seeking to improve care and reduce costs associated with avoidable hospitalizations and inappropriate ED use among Medicaid's highest-need, highest-cost populations.<sup>20</sup> Such efforts often invest in care management and establish medical or health homes that promote ongoing primary care relationships and coordinate services across the spectrum of medical, behavioral, and social support needs. These new care models depend on successful engagement of targeted beneficiaries, their willingness to develop relationships with care managers and other clinicians, and their ability to prioritize their chronic illness care. For the homeless, however, managing chronic illness can understandably fall second to higher priority needs such as finding a safe and stable place to live.

New York's Chronic Illness Demonstration Project (CIDP), for example, found addressing housing issues an integral first step to meeting health care needs. The state launched six pilot initiatives to improve care management for high-need, high-cost patients in fee-for-service who were at greatest risk for unnecessary hospitalizations. Across the six pilots, project partners acknowledged the significant proportion of enrollees who lacked stable housing. As a result, care managers were investing considerable efforts to connect enrollees with housing opportunities before they could be engaged in health-care related discussions. Patients who were homeless or precariously housed were more likely to name the ED as their usual source of care and to have a hospital admission associated with substance use or mental health diagnoses.<sup>21</sup>

Thus, a key finding from CIDP was the pressing issues related to housing facing many high-need, high-cost Medicaid beneficiaries. In recognition, within its new Medicaid health home service option, New York is requiring all health home providers to have direct partnerships with housing agencies to encourage successful engagement in chronic care management activities.

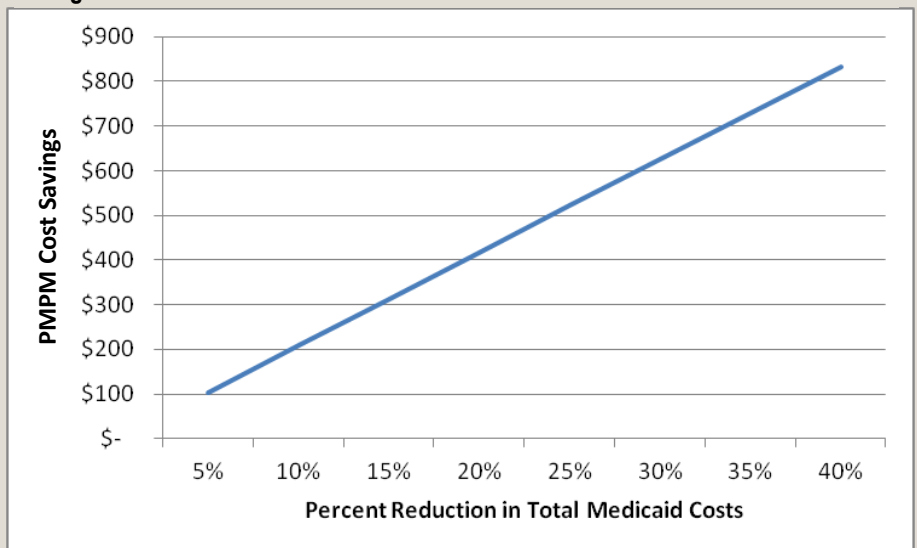
To determine whether investment in supportive housing-based care management would be financially viable, states should consider the cost-savings that could be generated through resulting impacts on overall health care spending. The business case for Medicaid financing of care management linked to affordable housing rests on the magnitude of expected savings relative to the costs of providing these additional services. At a minimum, states will look for a break-even scenario, whereby the reimbursement for such care management services is cost-neutral to the state through cost offsets achieved, for example, through reduced inpatient and ED costs.

### Example: Return on Investment for Medicaid-Funded, Supportive Housing-Based Care Management

Suppose a state is preparing for the 2014 Medicaid expansion and anticipates enrollment of 500 high-need, high-cost homeless adults in one region. Using data from a Washington State high-risk care management initiative,<sup>22</sup> assume that the baseline Medicaid expenditure for this high-risk population averages \$25,000 per year, or \$2,083 per member per month (PMPM). Using this estimate, Exhibit 1 presents cost-saving scenarios that could be achieved through successful implementation of these services. To note, whereas some of the studies mentioned earlier suggest achievable savings on order of 40 percent or greater, the chart includes a more conservative range of anticipated savings.

**Exhibit 1: Potential Medicaid Cost Savings Through Supportive-Housing Based Care Management**

As the chart illustrates, if the supportive-housing based care management services generated a 15-20 percent reduction in total Medicaid costs--a seemingly reasonable estimate based on published studies--these savings would equal between \$300-\$400 PMPM. Since these estimates exclude the cost of care management services, Medicaid should be willing to support up to \$300-400 in PMPM care management fees, as such an investment would be cost-neutral from a state budget perspective and would likely generate better health outcomes and reduced rates of expenditures over time. To the extent that care management fees were lower than this threshold, the investment would result in net savings to the state.



If such services are provided through the new health home option, states could generate even greater savings given the enhanced federal matching funds available during the first two years of implementation. Building on the example above, if the state designed care management services to meet health home requirements, it could draw down 90 percent federal match and thereby reduce the outlay of state funds to \$30-40 PMPM for the first two years of the program, resulting in near-term net savings of \$120-160 PMPM. Alternatively, the state could increase the care management fee it is willing to pay up to five-fold and still maintain cost-neutrality.

An important caveat to this analysis is that all costs and savings for the expansion population will be borne by the federal government until 2019, when states begin to contribute up to 10 percent match over time. States can use this period of federal financing to bend the cost curve for when the state share is activated. In addition, unlike the state, risk-based managed care organizations (MCOs) will have full incentive to invest in strategies with the potential to reduce overall expenditure from the point of initial enrollment (as their payment is not dependent upon the mix of federal/state funding).

## Business Case 2: A Supportive Housing Lens

States and housing agencies can typically use a variety of capital sources to pay for the “bricks and mortar” costs of supportive housing and various rental assistance programs can be used to subsidize rent for very low-income people. Covering the cost of supportive services or assuring tenants have access to effective services, however, remains the most challenging part of the supportive housing financing puzzle. Medicaid can potentially offer a more sustainable funding source for services for people living in supportive housing than the current patchwork of local and state resources including federal block grant funds subject to cuts, philanthropic grants, or special appropriations.

### Example: Comparing State Grant Funding vs. Medicaid to Cover Supportive Housing Services

Suppose a state is seeking to create 500 units of supportive housing for homeless people with chronic health challenges. Based on prior experience, the state recognizes that the cost of the housing-based supportive services is \$6,000 per unit per year. In the past, the state has financed 100 percent of these services using block grant funds and special appropriations. Using the same grant-funded model, the total annual state cost of adding these 500 units would be \$3 million. Such a large state investment seems extremely unlikely given the current budget shortfall environment.

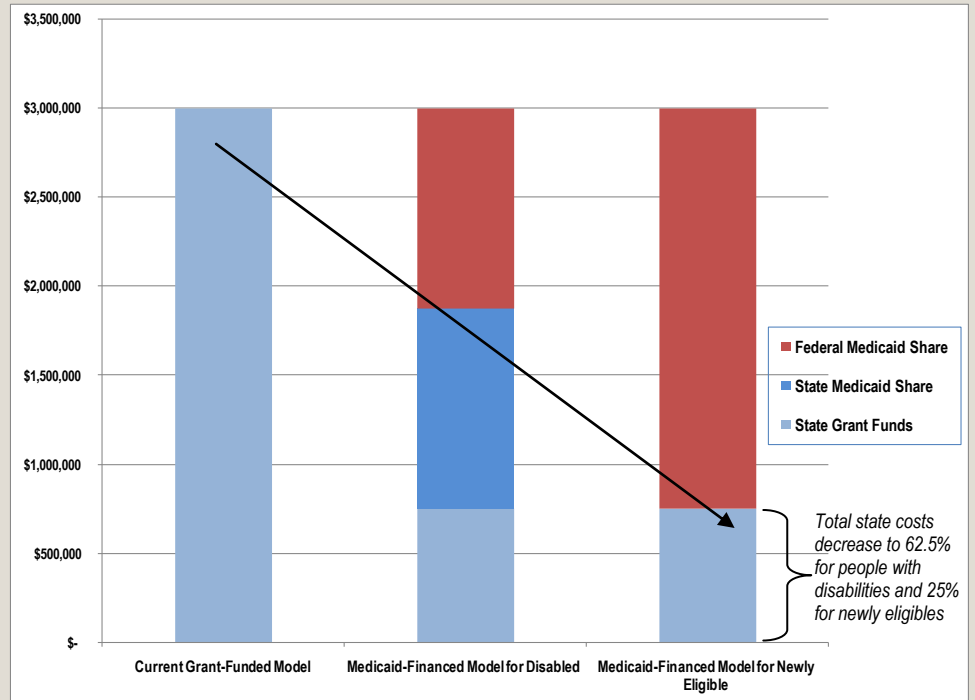
On the other hand, if the state provided supportive services as part of its state Medicaid plan, the state could use federal (and state) Medicaid dollars to fund service costs for eligible individuals. Suppose the state conducts a crosswalk analysis to determine the supportive housing services that are eligible for Medicaid reimbursement (see later examples of state crosswalks) and finds that 75 percent of the services in supportive housing can be funded through Medicaid, but that 25 percent still requires grant funding at \$1,500 per unit per year. Exhibit 2 compares the state’s fiscal impact of using a 100 percent grant-funded approach to financing supportive housing services with Medicaid-financed approach.

*Exhibit 2: State and Federal Cost of Services for a 500-Unit Supportive Housing Initiative*

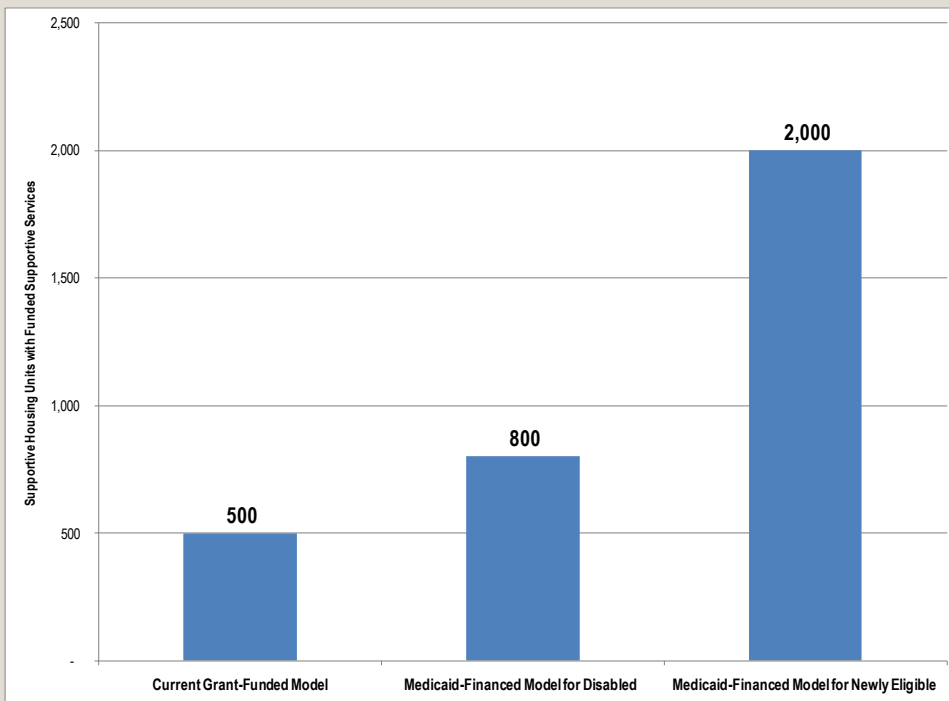
	Current Non-Medicaid Model	Medicaid Model for Disabled (50% Federal Matching Rate)	Medicaid-Financed Model for Newly Eligible (100% Federal Matching Rate)	Medicaid-Financed Model for Newly Eligible (90% Federal Matching Rate)
<b>Total Cost of Supportive Housing Services</b>	\$ 3,000,000	\$ 3,000,000	\$ 3,000,000	\$ 3,000,000
<b>% of Supportive Housing Services that are Medicaid Eligible</b>	0%	75%	75%	75%
<b>Total Medicaid Coverage</b>	\$ 0	\$ 2,250,000	\$ 2,250,000	\$ 2,250,000
<b>Federal Medicaid Share</b>	\$ 0	\$ 1,125,000	\$ 2,250,000	\$ 2,025,000
<b>State Medicaid Share</b>	\$ 0	\$ 1,125,000	\$ 0	\$ 225,000
<b>State Grant Funds</b>	\$ 3,000,000	\$ 750,000	\$ 750,000	\$ 750,000
<b>Total State Costs</b>	<b>\$ 3,000,000</b>	<b>\$ 1,875,000</b>	<b>\$ 750,000</b>	<b>\$ 975,000</b>

**Exhibit 3: State and Federal Costs of Services in 500 Supportive Housing Units Comparing Grant- vs. Medicaid-Financed Model**

For people who are homeless and eligible for SSI, in a state where the federal matching rate is 50 percent, the state costs of supportive-housing based care management services under a Medicaid-financed model would be 62.5 percent of what it would be if it used a state grant-funded model (\$1.875 million vs. \$3 million). For newly Medicaid eligible populations for whom the federal matching rate will initially be 100 percent starting in 2014,<sup>23</sup> a Medicaid-financed model would enable a state to finance the services in supportive housing at 25 percent (\$750,000 versus \$3 million) of what it would cost the state under a grant-funded model (see Exhibit 3).



**Exhibit 4: Supportive Housing Units with Services Funded Via \$3 Million State Investment**



Another way to illustrate the business case for states is by asking the question, for how many units of supportive housing could a state “buy” the services, given a certain level of investment of state dollars? Under a grant-funded model and assuming a per recipient per year cost of services of \$6,000, a \$3 million investment of state resources could cover service costs for 500 tenants of supportive housing. By using Medicaid to provide these services, on the other hand, the state could spend the same amount and leverage \$1.8 million in federal Medicaid matching funds for disabled (SSI) populations and \$9 million in federal matching funds for newly eligible, allowing for the financing of services in 800 and 2,000 units respectively (see Exhibit 4).

## Opportunities for Integrating Medicaid and Supportive Housing

In developing funding strategies for supportive housing services, it is important to identify whether, and to what extent, these services are reimbursable under Medicaid. The types of services provided in supportive housing generally belong to categories of Medicaid-eligible services known either as “case management,” “rehabilitative,” or “home and community-based services.” Recent crosswalk analyses of supportive housing projects suggest that as much as 60 percent of services provided and 85 percent of time spent on these kinds of services provided in a supportive housing environment are potentially reimbursable under the Medicaid program.<sup>24</sup> However, the extent of service alignment with Medicaid benefits will vary by state.

States can use Medicaid program rules in a variety of ways to fund supportive-housing based care management services. In determining the optimal strategy, states will need to consider which authorities best meet program objectives and conform with their Medicaid state plan structure and anticipated changes resulting from health reform. Following are three ACA-related opportunities for integrating Medicaid and supportive housing:

- **New Health Home State Plan Option**

The ACA established a new Medicaid state plan option for health home services for Medicaid enrollees with at least two chronic conditions (which could include a substance use disorder), one condition and risk of developing another, or at least one serious and persistent mental health condition. This option provides states with 90 percent federal match for these services for eight quarters. Given the high prevalence of mental health and substance abuse conditions in the chronically homeless population as well as the match between health home services and the services provided in

supportive housing, this new option could be a good fit. Health home eligibility cannot be determined by “homelessness” *per se* (eligibility is determined by an individual’s chronic conditions); however, care management linked to affordable housing could be part of a broader state health home strategy.

- **Home- and Community-Based State Plan Option (1915(i))** Section 1915(i) of the Social Security Act, as authorized by the Deficit Reduction Act (DRA) of 2005 and amended by ACA, provides states an option to offer home- and community-based services (HCBS) through an amendment to their state Medicaid plan to individuals who do not meet the institutional level of care criteria for eligibility required of participants in a 1915(c) HCBS waiver. Since the 1915(i) authority is not subject to the same budget neutrality requirements as a 1915(c) waiver, it also provides a mechanism to extend HCBS-type services to people with serious mental illness and substance use disorder who would generally not meet these requirements (because Medicaid does not cover Institutions for Mental Disease [IMDs] for adults aged 22-64.) Under this option, states set functional criteria for eligibility and may extend the 1915(i) benefit to individuals otherwise eligible for state plan services up to 150 percent of the federal poverty level.

ACA amendments to the DRA broaden the scope of HCBS services that may be covered under this option and give states the ability to target specific populations and provide various 1915(i) services to different populations. As a result, the scope of services that may be provided through this option are potentially a good match with services offered in a supportive housing environment and the new provisions potentially allow for



targeting of services based on particular chronic conditions, such as mental health and/or substance abuse. As in the case of the health home options, “homelessness” may not be used as functional criteria for eligibility, but could still have a role in targeting services to supportive housing residents. At the same time, however, states using this option are required to have similar eligibility rules and 1915(i) benefits statewide; hence, this option does not allow states the ability to target geographically within a select region. ACA also eliminated DRA provisions giving states the ability to control the growth of costs under 1915(i) through enrollment caps. In exploring this option, therefore, states will have to assess whether this mechanism allows for the effective targeting of high-need populations in supportive housing and the risk of potential fiscal exposure if the functional criteria are too broad.

- **Medicaid Rehabilitation and Targeted Case Management Services**

In addition to the two above ACA provisions, federal Medicaid regulations also give states the option to provide rehabilitation and targeted case management services. To varying degrees, both of these mechanisms could be used to fund services for individuals in supportive housing. In deciding the best approach to use, states will need to consider: (a) the authorities currently employed in a state’s Medicaid state plan and how the supportive housing strategy can be integrated into these plans; (b) the Medicaid strategy that will most closely target the populations that will be the focus of supportive housing; and (c) the Medicaid mechanism that will best fit with the services that states want to deliver in supportive housing settings.

In addition to the three opportunities described above, states may also consider working with Medicaid MCOs to provide care management services in supportive housing projects for homeless individuals. The number of Medicaid recipients nationwide who are enrolled in comprehensive, risk-based managed care has risen dramatically over the last 15 years, with nearly half of Medicaid enrollees now enrolled in full-risk managed care, and up to 71 percent in MCOs when partial-risk arrangements (e.g., PCCM) are considered.<sup>25</sup> While low-income children and non-disabled adults are generally more likely to be enrolled, 28 percent of all Medicaid enrollees with disabilities – in 39 states and the District of Columbia – are now enrolled in comprehensive risk-based managed care. This number is expected to grow as states, in an era of tight resources, increasingly seek ways to better manage both costs and care, particularly for high-need, high-cost populations.

Medicaid MCOs have the flexibility to add services beyond the basic Medicaid service package to address particular enrollee needs and better manage services within their capitation rates. Up until now, very few MCOs have used this flexibility to provide services in supportive housing settings. People who are Medicaid-eligible currently make up a small percentage of supportive housing residents and those individuals who are eligible may be enrolled in different managed care plans, decreasing the financial viability of an individual plan’s investment in care management linked to supportive housing. Through the ACA, however, the eligibility landscape will change and individuals in permanent supportive housing and those who are chronically homeless who could benefit from such housing will now be eligible for Medicaid. To the extent a state employs comprehensive risk-based managed care for these newly eligible beneficiaries, plans will have financial incentive to seek ways to

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MCOs under contract with the state have the flexibility to add services beyond the basic Medicaid service package to address particular enrollee needs and better manage services within their capitation rate.

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Involving Medicaid managed care networks in supportive housing offers the advantage of using Medicaid's traditional purchasing leverage to encourage intensive care management linked to affordable housing for individuals with chronic needs who are homeless.

effectively manage the costs of these enrollees.

States have a number of tools available to support collaboration between Medicaid MCOs and supportive housing providers. To begin, Medicaid agencies can help make the linkages between individual supportive housing providers and MCOs and help educate MCO leadership on the potential fiscal savings and health outcome improvements that can be anticipated from this approach. In partnership with MCOs and supportive housing, states can guide the development of an approach to provide housing-based services that meet the needs of chronically homeless individuals and that represent effective use of Medicaid resources. States can also explore options for enrolling individuals who are homeless or in permanent supportive housing in an MCO with particular capacity for managing the complex needs of this population. Finally, states can also use managed care contracts to direct special attention to this population and the provision of housing-based services.

In a managed care environment, Medicaid engagement in supportive housing will require MCO commitment. Likewise, supportive housing providers will need to be open to new models to leverage managed care resources; for example, MCO care coordination teams could work across supportive housing developments.

### **Policy Considerations**

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Integrating care management with supportive housing represents a viable way to shift spending from expensive acute and emergency care for beneficiaries with chronic health problems to more primary and preventive care, and contain Medicaid costs in the process. However, the path that states and communities may take to achieve the potential of supportive housing will likely vary and will require a solid commitment for all participants. As a first step, states will need to determine which Medicaid authorities, as detailed earlier, will

best allow the financing of services in supportive housing. Additional issues for states to address are outlined below.

1. *States and local housing providers will need to ensure that supportive housing is targeting high-need, high-cost, chronically homeless individuals.*

While all homeless individuals can benefit from the type of services provided in supportive housing, the Medicaid business case is particularly strong when these services are targeted to individuals who are likely to be frequent users of acute and emergency room care in the absence of supportive housing. This may require new processes and/or technologies to identify high-cost, chronically ill clients who could most benefit from supportive housing. States and MCOs have experience with predictive modeling and local housing communities have likewise used various technologies to stratify clients, including administrative data matching, probabilistic algorithms, and vulnerability indices. Based on this experience, strategies must be developed and implemented for identifying, recruiting, and reaching the population whose health care utilization is most likely to be impacted through this approach.

2. *States will need to determine which Medicaid payment methods to employ in reimbursing services in a supportive housing environment.*

States (or their MCOs) must evaluate which payment methods – e.g., fee-for-service reimbursement, per diems, bundled monthly rates, risk-adjusted case rates, capitation, among others – are the best fit for reimbursing services in supportive housing. In particular, states need to identify what payment method will best promote the goals of managing the costs of clients with complex medical needs and ensuring high quality of care.

3. *Technical assistance and/or new organizational configurations are needed to help bridge the gap between current supportive housing capacity and Medicaid requirements (e.g., billing, quality).*

The capacity of supportive housing organizations will need to be strengthened to support their efforts to serve as providers and appropriately bill for services under the Medicaid program. States and/or MCOs should be ready to provide technical assistance to supportive housing providers and facilitate their enrollment and participation in the Medicaid program. This may include providing assistance to existing providers to structure, track, and describe the services they deliver in terms that will allow for Medicaid billing and payment.

Alternatively, current providers of Medicaid services can play a role in providing services in supportive housing. For example, health home teams or MCO community-based care managers could potentially support beneficiaries residing in supportive housing environments. Administrative services organizations (ASOs) could serve as intermediaries between supportive housing providers and Medicaid, specifically to conduct centralized tracking and Medicaid billing on behalf of providers.

4. *Systems and methods are needed for tracking and managing costs for people who are chronically homeless.*

States and housing providers will need data and information systems that can track health outcomes, service utilization, and costs once clients are receiving services in supportive housing settings. Such “real-time” systems can help ensure that savings are being realized to offset the cost of services and help build the case for future investment in these services.

Depending on the state strategy employed, MCOs or ASOs could be used to track and manage service delivery, outcomes, and costs.

## Conclusion

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There is compelling evidence that a combined intervention of stable, affordable housing along with supportive services can pay off in reduced utilization of crisis and inpatient services, resulting in better health care outcomes for individuals with complex needs who are homeless, and improved management of costs for Medicaid. There are also potential benefits to other public systems, such as corrections to the extent that the model can reduce incarceration rates among targeted populations. Developing strategies to use Medicaid-funded services to address the health needs of supportive housing residents, and overcoming the aforementioned policy challenges, could represent a good investment opportunity for states – particularly as national health reform expands Medicaid eligibility to all individuals with incomes below 138 percent of the federal poverty level. In short, it is an investment that states should consider as part of their preparation for implementing the ACA in 2014.

## About the Authors

**Michael Nardone**, former Pennsylvania Medicaid director and currently a principal at Health Management Associates, contributed to this brief as a CHCS senior program consultant; **Richard Cho** is the director for innovations and research at the Corporation for Supportive Housing; and **Kathy Moses** is a senior program officer at CHCS.

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## About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care access and quality for low-income Americans. CHCS 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](http://www.chcs.org).

## About the Corporation for Supportive Housing

For over 20 years, CSH has led the national supportive housing movement. It has helped communities throughout the country transform how they address homelessness and improve people's lives. CSH develops innovative program models, provides research-backed tools and training, offers development expertise, and collaborates on public policy and systems reform. And, CSH is a certified community development financial institution (CDFI). As such, CSH makes it easier to create and operate high-quality affordable housing linked to services. To date, CSH has made over \$300 million in loans and grants, and has been a catalyst for over 150,000 units of supportive housing. For more information, visit [csh.org](http://csh.org).

## Endnotes

- <sup>1</sup> *The 2010 Annual Homeless Assessment Report (AHAR) to Congress*. US Department of Housing and Urban Development, Office of Community Planning and Development. Available at <http://www.hudhre.info/documents/2010HomelessAssessmentReport.pdf>.
- <sup>2</sup> L. Sadowski, R. Kee, T. VanderWeele, and D. Buchanan. "Effect of a Housing and Case Management Program on Emergency Department Visits and Hospitalizations among Chronically Ill Homeless Adults." *Journal of the American Medical Association*, May 6, 2009, pp. 1771-1778.
- <sup>3</sup> *The 2010 Annual Homeless Assessment Report to Congress*, op cit.
- <sup>4</sup> M. Larimer, D. Malone, M. Garner, et al. "Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problems." *Journal of the American Medical Association*, April 1, 2009, pp. 1349-1357.
- <sup>5</sup> *Home and Healthy for Good: A Statewide Pilot Housing First Program*. Massachusetts Housing and Shelter Alliance, June 2007.
- <sup>6</sup> K. Linkins, J. Brya, and D. Chandler. *Frequent Users of Health Services Initiative: Final Evaluation Report*. Lewin Group, August 2008.
- <sup>7</sup> M. Raven, J. Billings, L. Goldfrank, et al. "Medicaid Patients at High Risk for Frequent Hospital Admission: Real Time Identification and Remediable Risks." *Journal of Urban Health*, March 2009, pp. 230-241.
- <sup>8</sup> AHAR report, op.cit.
- <sup>9</sup> U.S. Department of Health and Human Service (HHS), Health Resources and Services Administration (HRSA), Bureau of Primary Care. 2008 National Homeless Summary Data.
- <sup>10</sup> *Summary of Studies: Medicaid/Health Services Utilization and Costs*. Corporation for Supportive Housing, September 2009. Available at <http://documents.csh.org/documents/policy/UpdatedCostMatrixSept09.pdf>.
- <sup>11</sup> J. Perlman and J. Parvensky. *Denver Housing First Collaborative Cost Benefit Analysis and Program Outcomes Report*. Colorado Coalition for the Homeless, December 2006. Available at: <http://shnny.org/research/denver-housing-first-collaborative/>
- <sup>12</sup> M. Larimer, op. cit.
- <sup>13</sup> T. Martinez and M. Burt. "Impact of Permanent Supportive Housing on the Use of Acute Care Health Services by Homeless Adults." *Psychiatric Services*, July 2006, Vol. 57, No.7.
- <sup>14</sup> L. Sadowski, op.cit.
- <sup>15</sup> Ibid.
- <sup>16</sup> K. Linkins, op.cit
- <sup>17</sup> M. Larimer, op.cit.
- <sup>18</sup> M. Mondello, A. Gass, T. McLaughlin, et al. "Cost of Homelessness: Cost Analysis of Permanent Supportive Housing, State of Maine, Greater Portland." Corporation for Supportive Housing, September 2007.
- <sup>19</sup> J. O'Connell and S. Swain. *Rough Sleepers: A Five Year Prospective Study in Boston, 1999-2003*. Presentation, Tenth Annual Ending Homelessness Conference, Massachusetts Housing and Shelter Alliance, Waltham, MA 2005.
- <sup>20</sup> S. Allen and A. Croke. *The Faces of Medicaid: The Complexities of Caring for People with Chronic Illnesses and Disabilities*. Center for Health Care Strategies, Inc., October 2000.
- <sup>21</sup> M Raven, op. cit.
- <sup>22</sup> J. Bell, D. Mancuso, T. Krupski, et al. *A Randomized Controlled Trial of King County Care Partners' Rethinking Care Intervention: Health and Social Outcomes up to Two Years Post-Randomization*. Technical Report by Center for Healthcare Improvement for Addictions, Mental Illness and Medically Vulnerable Populations (CHAMMP), March 2012.
- <sup>23</sup> For states that had already expanded Medicaid eligibility to parents and childless adults up to 100% of FPL or higher prior to December 2009, the initial match rate for the newly federally Medicaid eligible population will be 50 percent of gap between that state's current match rate and the 100 percent match non-expansion states receive. This will increase gradually until 2019 when all states will receive a 90 percent federal match for the newly eligible population.
- <sup>24</sup> *Implementation of the Affordable Care Act and Medicaid Reform in Illinois to Incorporate Permanent Supportive Housing*. Corporation for Supportive Housing; Heartland Alliance; Health and Disability Advocates, August 2011. Available at: <http://www.csh.org/resources/implementation-of-the-affordable-care-act-and-medicaid-reform-in-illinois>
- <sup>25</sup> Medicaid and CHIP Payment and Access Commission (MACPAC). *The Evolution of Managed Care in Medicaid*, Report to Congress, June 2011.