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Linking Medicaid and Supportive Housing: Opportunities and On-the-Ground Examples

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Introduction

Research suggests that a broad range of social factors affect individual and population health. Indeed, acknowledging the role of social factors in determining health, the U.S. Department of Health and Human Services' *Healthy People 2020* report included as one its four overarching goals for the 2010-2020 decade: "Create social and physical environments that promote good health for all."¹ Housing has been identified as one such social determinant of health, as individuals experiencing homelessness or unstable housing situations face significant challenges in obtaining care and managing chronic conditions, and lack of housing and poor housing conditions can themselves adversely affect health. There is growing evidence that supportive housing can contribute to improved health outcomes for individuals experiencing homelessness or at risk of homelessness.² Supportive housing can also promote the goal of community integration of individuals with disabilities and elders who need long-term services and supports (LTSS).

Low income, poor health, and unstable housing are often intertwined. For that reason, opportunities to deploy supportive housing resources and Medicaid strategically to improve outcomes for individuals receiving services in both sectors are of policy interest. Federal law prohibits federal matching of state Medicaid spending for room and board (except for nursing facility services, which are a covered Medicaid benefit). However, Medicaid can cover and finance a wide range of housing-related services and activities for individuals enrolled in Medicaid. The Affordable Care Act (ACA)'s expansion of Medicaid to millions of uninsured adults with income up to 138 percent of the federal poverty level (FPL), including many with supportive housing needs, increased the potential impact of Medicaid-housing collaborations.

This issue brief outlines ways in which Medicaid can support integrated strategies and, based on telephone interviews with key informants, profiles three current initiatives that illustrate distinctly different approaches to linking Medicaid and supportive housing. The three initiatives include one launched by a city (Philadelphia), one by a state (Louisiana), and one by a Medicaid MCO (Mercy Maricopa Integrated Care in Phoenix, Arizona). They target special populations including homeless individuals, people with a wide range of disabilities, and adults with mental health and/or substance use problems.

Setting the context

RESEARCH SHOWS AN ASSOCIATION BETWEEN SUPPORTIVE HOUSING AND IMPROVEMENTS IN RESIDENTS' HEALTH OUTCOMES AND COSTS.

Homelessness is a strong predictor of poor health outcomes.³ Homelessness and housing instability are also predictors of higher health care costs, due largely to high rates of potentially avoidable hospital admissions.⁴ Research on supportive housing suggests that it can have a positive impact on the health of formerly homeless individuals,⁵ many of whom are covered or could be covered by Medicaid. The findings from evaluations of various supportive housing programs across the country include improved health status, better mental health outcomes, and reduced substance use among those who gain housing. For example, two studies of housing programs serving individuals living with HIV/AIDS showed significantly higher survival rates among those who obtained supportive housing than among individuals in a control group who did not.⁶ Other research has shown reduced emergency department (ED) use and inpatient hospital admissions, as well as reduced Medicaid costs, associated with supportive housing.⁷ While these studies have generally been small in scale, they indicate that stable housing and housing-related services and supports for Medicaid beneficiaries may help to advance the “Triple Aim” of improving patient care and population health and lowering per capita health care costs.

MEDICAID AND SUPPORTIVE HOUSING PROGRAMS CAN BE EFFECTIVE PARTNERS.

Although Medicaid and supportive housing programs serve many of the same people, they have historically operated in separate “silos,” with little if any interaction at the federal, state, or local levels. Medicaid and housing programs each have complex rules and structures and their institutional cultures differ. The federal government and states jointly finance Medicaid, and subject to federal minimum standards, states design and operate their own programs. As a result, Medicaid benefits, delivery and payment systems, and other aspects of program design vary widely by state. On the housing side, federal dollars often flow through local governments and public housing agencies to housing providers, adding to the complexity that Medicaid-Housing collaborations may face. Partnerships require the two sectors to gain understanding of each other’s operations and develop new relationships and systems to support coordination.

Besides providing housing for low-income and special needs populations, supportive housing programs provide housing-related services and activities. These include assistance with securing housing and transition support services for individuals being discharged from institutional settings to the community, and health-related services, such as helping residents obtain and maintain Medicaid coverage, coordinating their care, and providing health education and wellness programs. Staff who provide these services are typically onsite and know their residents, so they are well-positioned to participate in residents’ care management.

Historically, housing programs have financed the housing- and health-related services they provide with a combination of rental income and private foundation grants, or with funding provided by the federal Department of Housing and Urban Development (HUD) for this purpose. However, state Medicaid programs also have substantial flexibility to cover certain housing-related services and activities for Medicaid enrollees. Because many residents of supportive housing are covered or could be covered by Medicaid, Medicaid and housing programs can be effective partners. Further, in states that have implemented the ACA Medicaid

expansion, millions of previously uninsured low-income adults, including homeless adults and others able to live in the community with appropriate supports, now have Medicaid coverage. Thus, the case for and potential benefits of coordination between Medicaid and supportive housing programs merit increased consideration.

MEDICAID-HOUSING LINKAGES MAY HELP OPTIMIZE RESOURCES AND ADVANCE COMMUNITY INTEGRATION.

In cross-sector initiatives that integrate Medicaid and housing, the whole that results may be greater than the sum of the parts. Providing Medicaid coverage and payment for health- and housing-related services otherwise financed with housing dollars can augment housing programs' capacity to address housing needs; in addition, state Medicaid spending for these services and activities increases the funds available for assistance for supportive housing clients and residents. Integration of Medicaid and housing may also foster the mutually reinforcing positive effects of safe, stable housing and access to health care for the vulnerable populations who need both. Examples of such effects may include improved medication adherence, reductions in avoidable emergency department use and hospital admissions, housing retention, and increased household income. Medicaid-housing collaborations may also advance community integration of seniors and people with disabilities who need long-term services and supports (LTSS). As "whole person" delivery models that seek to knit together physical and behavioral health care, acute and long-term care, institutional and community-based services, and social supports gain more traction in Medicaid, and as Medicaid and housing programs gain experience interacting with each other and assess the impact of their joint initiatives, interest in coordinated efforts is growing.

Medicaid coverage of housing-related services

On June 26, 2015, the Centers for Medicare and Medicaid Services (CMS) issued an [Informational Bulletin](#) to "assist states in designing Medicaid benefits, and to clarify the circumstances under which Medicaid reimburses for certain housing-related activities, with the goal of promoting community integration for individuals with disabilities, older adults needing long-term services and supports, and those experiencing chronic homelessness."⁸ Beyond providing concrete guidance about what state Medicaid programs can pay for and how, the Informational Bulletin was significant because it recognized the importance of addressing housing needs to meet Medicaid programmatic goals. The Informational Bulletin outlines three types of housing-related activities and services that Medicaid can cover, as summarized below. Many of the Medicaid-reimbursable services are ones typically provided by housing organizations for residents.

- **Individual housing transition services** help individuals transition from institutions to community-based housing. These services include, among others, tenant screening and housing assessments that identify enrollees' preferences and barriers to successful tenancy; development of a housing support plan; assistance with the housing application and search process; assistance with one-time move-in expenses, such as security deposit; arranging for details of the move; and development of a crisis plan that includes prevention and early intervention services when housing is jeopardized.
- **Individual housing and tenancy sustaining services** help individuals maintain tenancy after housing is secured. Tenancy support services include education and training on tenants' and landlords' role, rights, and responsibilities; assistance in resolving disputes with landlords and neighbors to reduce the risk of eviction; assistance with housing recertification; and others.

- **State-level housing services** are “strategic, collaborative” activities to assist in identifying and securing housing resources. Among the activities for which Medicaid financing is available are development of agreements with local housing and community development agencies to facilitate access to housing resources, and participation in these agencies’ planning processes.

The Informational Bulletin also discusses the Medicaid options and waiver authorities that states can use to cover housing-related services and activities. The mechanisms available to states include: home and community-based services under section 1915(c) waivers or the Medicaid state plan; targeted case management services; managed care under section 1915(b) waivers, the optional Community First Choice benefit and Money Follows the Person demonstration established by the ACA; and section 1115 demonstration waivers. A summary of these opportunities is provided in the Appendix to this brief.

Other Medicaid mechanisms for linking with supportive housing

In addition to the state plan and waiver authorities that states can use to integrate Medicaid and supportive housing, a variety of delivery system and payment models also offer opportunities and, in some cases, incentives, to build such linkages. Growing evidence on the connections between social and health disadvantages; the focus on the “Triple Aim” of improving the patient care experience and population health while reducing the per capita cost of health care; and the ACA’s large investment in innovative and accountable health care delivery have all enhanced the environment for more integrated approaches to providing care for Medicaid beneficiaries. The following mechanisms are particularly relevant in this regard.

MANAGED CARE PLAN INITIATIVES

Most state Medicaid programs rely heavily on risk-based managed care organizations (MCOs) to serve Medicaid enrollees. Many states are expanding their managed care programs beyond children and parents to include beneficiaries with more complex needs, including individuals with behavioral health conditions, seniors, and persons with physical disabilities; a growing number of states are also providing long-term services and supports through managed care. Medicaid managed care plans, which are paid on a capitation basis by states, have both incentives and some flexibility to invest in measures to improve care and reduce costs. MCOs may use their capitated funding to pay for care management and housing-related services and activities to the extent they are covered under the Medicaid state plan. Some states may permit plans to use part of their savings for “reinvestment strategies” that may cover some of the costs of innovative models if they can achieve offsetting savings. MCOs may invest some of their own profits in services and activities not specifically defined as Medicaid benefits, but they must generally get state approval to use their capitated funding this way.⁹ Plans can also take the initiative to partner with housing agencies or organizations, foundation programs, or other entities to support integration of health services and housing-related activities for their Medicaid members.

HEALTH HOMES

The ACA established a new Medicaid state plan option for “health homes” for Medicaid beneficiaries with multiple chronic conditions or a serious mental illness. Health homes integrate physical and behavioral health (both mental health and substance abuse) services and long-term services and supports for high-need, high-

cost Medicaid populations. Health homes operate under a “whole person” philosophy that involves not just better coordinating care for an individual’s physical conditions, but also linking the person to needed long-term services and supports in the community, social services, and family services. The model is designed to improve health care quality and reduce costs.¹⁰ States that implement the health home option receive a 90-percent federal match for eight quarters for health home services provided by state-designated health homes to their enrolled beneficiaries. Services eligible for the enhanced match include, among others, comprehensive transitional care and referral to community and support services.

STATE INNOVATION MODELS

Through the State Innovation Models (SIM) initiative, the CMS Innovation Center has awarded close to \$1 billion in grants to over half the states to design, test, and evaluate multi-payer delivery system and payment reforms designed to improve health system performance, increase the quality of care, and reduce costs for Medicaid, CHIP, and Medicare beneficiaries and all residents of the state. In general, the cornerstone of the state innovation models is comprehensive, patient-centered primary care, and the models envision more highly integrated systems of care and payment tied to value. Notably, most SIM states, in devising new models of care and care linkages, have explicitly addressed social determinants of health. All 11 states most recently awarded model testing grants link or plan to link primary care and community-based organizations and social services. Most SIM states also incorporate accountable care organizations, described next.

ACCOUNTABLE CARE ORGANIZATIONS

A number of states are reorganizing part or all of their Medicaid delivery system into accountable care organizations (ACOs) – provider-led, integrated care delivery systems that are financially accountable and responsible for the care, health care quality, outcomes, and costs of a defined beneficiary population. In some states, the providers in an ACO share in Medicaid savings achieved by the ACO; in other states, ACOs operate on the basis of a global budget. ACOs, like MCOs, have incentives and flexibility to work with housing organizations if they determine that providing supportive housing and/or housing-related services would promote their health outcome and cost goals. To illustrate, Oregon’s 1115 waiver permits the state’s coordinated care organizations, in which most Medicaid beneficiaries are enrolled, to use Medicaid dollars for non-medical “flexible services” for Medicaid enrollees that can result in better health at lower costs, including housing supports such as critical repairs, ramps, and move-in expenses.

Models of integration: Three case examples

CITY OF PHILADELPHIA: COMBINING HOUSING AND HEALTH CARE RESOURCES TO REDUCE CHRONIC HOMELESSNESS

Background

A “recovery-oriented system of care” is central to the City of Philadelphia’s effort to end chronic homelessness. This approach involves providing the clinical care that individuals need to address their mental health or substance use challenges, and also ensuring that they have the social and other supports they need to participate in school or work and be part of their communities. Integrating physical and behavioral health care is also key to the model. The success of Philadelphia’s approach depends, in significant measure, on the availability of Medicaid-covered services and payment.

Medicaid's role

A key feature of the relationship between Pennsylvania's Medicaid agency and the counties in the state has been instrumental to Philadelphia's progress in reducing homelessness. Specifically, while the Medicaid agency contracts with managed care plans to provide physical health services for Medicaid beneficiaries, the state gives counties the opportunity to manage behavioral health services for its residents. The City of Philadelphia, which is also a county, established a single-payer system for public behavioral health care in its jurisdiction. The City's Department of Behavioral Health and Intellectual Disability Services (DBHIDS) receives capitation payments totaling about \$800 million from the Medicaid agency and is at full financial risk for the administration of the Medicaid behavioral health benefit for approximately 600,000 Medicaid enrollees.

The vast majority of people served by DBHIDS – roughly 85 percent – are Medicaid-eligible. The City of Philadelphia also receives state and federal block grant funds to cover people who are not eligible for Medicaid and services that are not covered by Medicaid. The City is able to tailor behavioral health services to meet individual needs and manages these multiple funding streams behind the scenes. Through implementation of evidence-based practices, early intervention, and an emphasis on long-term recovery, DBHIDS has been able to achieve Medicaid savings and reinvest them in system improvements, including an initiative to house individuals experiencing homelessness, as described below.

Pathways to reducing homelessness

A core component of Philadelphia's strategy to end homelessness is its Permanent Supportive Housing (PSH) initiative, which involves DBHIDS and the City's Office of Homeless Services. Importantly, most individuals housed under the PSH initiative are eligible for Medicaid coverage, which provides a source of payment for the health services they receive. There are three different pathways to housing:

- **Housing First** serves more than 500 individuals facing chronic homelessness and severe psychiatric and/or substance use disorders. The premise of the Housing First model is that people need to be stably housed to benefit optimally from other services and supports; thus, participants do not have to comply with conditions like agreeing to psychiatric treatment before they move in. Once individuals are housed, the City provides them with clinical care, targeted case management, mobile psychiatric services, peer-to-peer services, and other services. Medicaid pays for these services for residents who are Medicaid beneficiaries.
- **Journey of Hope** is a residential substance use disorder treatment program for people with a history of chronic homelessness and long-term serious addiction. It was launched in 2007 after the City's Homeless Death Review found that drug intoxication/alcoholism was the leading cause of death among people experiencing homelessness. By 2014, Journey of Hope had helped 443 persons achieve a variety of desirable outcomes, such as reuniting with family, obtaining treatment for other health or mental health problems, and moving into PSH.
- **Safe Haven** is a City program that brings people indoors during inclement weather and uses the opportunity to engage them in treating their substance use problems and move them to PSH quickly. Nearly 220 people have moved into PSH through this program.

Results

Data on Philadelphia's PSH initiative show that, of the roughly 1,200 chronically homeless participants brought into PSH over the last eight years, 89 percent remain in stable housing and are not using crisis

services. DBHIDS' costs rose initially when the programs got underway because the use of behavioral health services increased among the individuals served. However, costs dropped substantially after people were housed. For example, the City's behavioral health costs were \$85 per day per person for individuals in the Safe Haven program two years prior to their entry into the program. These costs rose to \$112 during the engagement period, then fell to \$18 once the person was housed. Similar cost-saving patterns were seen in the other two programs.

Lessons learned

DBHIDS officials identified lessons from their experience that may be relevant to planning for other Medicaid-housing partnerships. Most importantly, a clinical framework based on pursuing long-term recovery is key for persons with addiction disorders. Dr. Arthur Evans, DBHIDS Commissioner, observed that addressing housing and other social determinants of health has helped to achieve annual savings averaging about \$15 million in the behavioral health care system. "If you factor in physical health outcomes, such as improvements in the management of chronic conditions like diabetes, hypertension, asthma and others," he said, "the savings can be even more robust." In addition, health care financing strategies are essential to operate the range of services needed; intentionally capturing Medicaid payment for services provided to eligible individuals in PSH is both appropriate and feasible, and can enable resources available for housing to go further.

LOUISIANA: AS PART OF DISASTER RECOVERY, HEALTH AND HOUSING AGENCIES PARTNER TO LAUNCH PERMANENT SUPPORTIVE HOUSING

Background

In the wake of Hurricanes Katrina and Rita in 2005, disaster recovery resources poured into Louisiana to support community rebuilding. Recognizing the significant overlap between the population experiencing homelessness and individuals with disabilities, a broad coalition of advocates came together to push for the creation of a supportive housing program. The Louisiana Department of Health and the Louisiana Housing Authority (LHA) formed a partnership to help secure a portion of the increased resources to establish a Permanent Supportive Housing (PSH) program with the dual policy goals of preventing and reducing both homelessness and unnecessary institutionalization among people with disabilities

Permanent Supportive Housing

Planning for the PSH program began in 2005, with the goal of building 3,000 housing units. Federal Low-Income Housing Tax Credits (LIHTC) and disaster recovery funding under the Community Development Block Grant (CDBG) were used to finance the housing. The tax credit program, which continues to finance the production of housing units, offers housing developers incentives to set aside five percent to 25 percent of their units for PSH, but additional rental subsidies were needed to make the units affordable for the very low-income target population. In 2008, the first year that housing units were occupied, Congress allocated additional rental subsidy vouchers that limited out-of-pocket rental costs to 30 percent of household income. Occupation of the new units accelerated in 2010 – the LIHTC projects awarded after Katrina took some years to build – and, thanks to additional rental subsidies, the state is now on track to house 3,545 households.

Louisiana's program has some distinctive features. First, the Louisiana Housing Authority (LHA), a unique state-level housing authority, operates within the Louisiana Housing Corporation. The Corporation administers the LIHTC program and works with LHA to identify and recruit PSH providers, and the LHA

administers the rental subsidies. The centralization of these activities at the state level allows Louisiana to implement a statewide program without having to seek rental subsidies from multiple local housing authorities, streamlining the process of setting up PSH units.

Medicaid's role

From the outset, the state realized that the CDBG funds authorized for disaster recovery were limited and that the PSH program had to be designed so that Medicaid funding could help sustain it over the long term. Louisiana accomplished this by using Medicaid state plan authority to cover tenancy support services. This action had a large impact because, since the PSH program targets very low-income individuals with disabilities, the vast majority of those in housing or receiving “pre-tenancy supports” (described below) were Medicaid beneficiaries, even prior to the state’s implementation of the ACA Medicaid expansion in June 2016. For the most part, PSH participants are single adults who typically have high needs and high service use. The program also serves families, and a household may be eligible for PSH based on having a child with a disability. Seventy percent of PSH tenants have more than one disability; 40 percent have three or more disabling conditions.

In addition to supporting services for the majority of PSH participants, Medicaid payments also contribute to achieving the state’s goals for promoting housing stability and averting unnecessary institutionalization of people with disabilities. Individuals transitioning from institutions to the community under Louisiana’s Money Follows the Person grant receive preference points for PSH.

Louisiana’s Medicaid program covers three phases of tenancy support services for Medicaid beneficiaries in PSH, as follows (Louisiana uses funds from other sources, including Ryan White, the Veterans Administration, and CDBG, to provide services for PSH tenants who do not qualify for Medicaid):

- **Pre-tenancy services** include assistance completing the housing application and understanding tenant rights and responsibilities, beneficiary engagement and planning for housing support needs, and assistance conducting the housing search and choosing a unit.
- **Move-in services** include arranging the actual move, ensuring the unit and individual are ready for move-in, and helping beneficiaries adjust to the new home and neighborhood.
- **Ongoing tenancy services** include supporting the beneficiary in achieving sustained, successful tenancy and personal satisfaction, and identifying the type, intensity, frequency, and duration of ongoing services, based on the beneficiary’s needs and preferences.

One tenancy supports provider, Crescent Care, is also a federally qualified health center. In addition to providing coaching and other assistance with maintaining a home, CrescentCare also helps participants connect with primary care, OBGYN, and dental services. “This is a big draw,” according to Bethney Whittington, PSH Supervisor. CrescentCare also helps sign children up for Medicaid and LACHIP, Louisiana’s Children’s Health Insurance Program. Whittington reflected on how the program has changed over time. “There was a time when people just couldn’t maintain their vouchers, but now they learn coping skills and get other supports,” she said. “Now, housing is sustainable and our patients’ recovery is sustainable.”

Louisiana provides these services under its section 1915(c) home and community-based services (HCBS) waivers for persons with disabilities and the mental health rehabilitation (MHR) benefit in the Medicaid state plan. Under the 1915(c) waivers, DHH defines “tenancy supports” as a distinct covered service, rather than a

component of case management services. According to Robin Wagner, Deputy Assistant Secretary of DHH's Office of Aging and Adult Services, this is because providing tenancy support services requires a special set of skills and activities, such as negotiating reasonable accommodations for people with disabilities and working with tenants and landlords when crises that threaten continued tenancy arise, that are outside what most care managers are prepared to do.

Louisiana made some strategic decisions with respect to providing Medicaid reimbursement for tenancy supports, especially for activities that do not involve face-to-face interaction with the Medicaid beneficiary. The state determined that covering these so-called "collateral contacts" was essential because tenancy support providers often spend considerable time working with others on the beneficiary's behalf. Louisiana included these activities in its definition of tenancy supports under its section 1915(c) waivers. Tenancy support services also have their own billing codes under the waivers and PSH providers are reimbursed for time spent on collateral contacts as well as time spent working directly with tenants. Louisiana covers tenancy supports as part of its MHR benefit, too, but they are not defined as a distinct service, and MHR rules do not permit providers to bill for time not spent face-to-face with clients. PSH providers operating within the MHR program are instead allowed to use a billing modifier that pays a slightly higher "complex care" rate for work with beneficiaries in PSH.

Louisiana established criteria that organizations must meet to become PSH tenancy support providers. They must be accredited to provide MHR services, enroll as providers in the state's 1915(c) waivers, and contract with the state's Medicaid MCOs. Providers also receive rigorous training related to tenancy support services before being approved to enroll and contract as PSH providers. Currently, 14 organizations provide tenancy support services in the state, and two more are seeking to become providers.

Results

Louisiana reports a 94 percent housing retention rate among the households that have entered the PSH program since it began housing tenants in 2008. "Retention" is defined as remaining in a PSH unit or moving on to another stable housing situation. A preliminary analysis by the Louisiana Department of Health shows statistically significant reductions in hospitalizations and emergency department utilization after the PSH intervention. And, an early independent analysis of the PSH program's impact on Medicaid spending, based on 2011-2012 data, found a 24 percent reduction in Medicaid acute care costs after a person was housed. The state also tracks the impact of PSH on household income, as tenants often receive assistance with finding employment or pursuing Social Security Disability benefits. In a study of PSH households in the New Orleans region, where the program is most mature, nearly 55 percent of households reported an increase in income following entry into the program.

Lessons learned

Louisiana officials consider having the "right" the number of PSH providers a key factor in running a high-quality program. Wagner explained, "The nature of the work and the population requires a focused and committed effort on the part of the provider, so each provider needs a sufficient pool of PSH clients to make that effort worthwhile." Louisiana does not limit the number of providers, but rigorous criteria for participation have kept the number at the right level to assure model fidelity.

The state found it helpful to employ, in addition to program management staff, personnel who work directly with clients as Tenancy Services Managers (TSM). TSMs are available to work with tenants who temporarily lose Medicaid, and they also can trouble-shoot and assist providers with the most difficult-to-serve clients. Because Louisiana’s is a “housing first” program, in which tenancy is not contingent on continuing or cooperating with services, TSMs also work to re-engage program participants who refuse services. TSM positions are funded using CDBG.

MERCY MARICOPA INTEGRATED CARE: A MEDICAID HEALTH PLAN-INITIATED SUPPORTIVE HOUSING PROGRAM

Background

Mercy Maricopa Integrated Care (Mercy Maricopa) is a nonprofit health care plan in Phoenix, Arizona, that manages behavioral health care for Medicaid-eligible adults and children, and some non-Medicaid members; Medicaid beneficiaries make up a large majority of the plan’s total enrollment. For adult Medicaid beneficiaries with serious mental illness (SMI), the plan provides integrated physical and behavioral health care. Adults who are Medicaid-eligible and are not seriously mentally ill receive mental health and substance abuse services from Mercy Maricopa and choose from several other plans for their physical health services.

Mercy Maricopa has long had a supportive housing program for its adult members with SMI, who make up 5 to 10 percent of the total adult membership. More recently, in 2014, a community crisis – the closure of the Men’s Overflow Shelter in Phoenix – put the health plan at the center of an effort to assist hundreds of additional adults experiencing homelessness. Responding to the crisis, Mercy Maricopa advanced the idea that, in addition to adults with SMI, adults with less serious mental health and substance use problems, who comprise about 40 percent of the plan’s total enrollment, also need supportive housing. “We wanted to be part of the solution,” recalled Tad Gary, the plan’s Chief Clinical Officer. “There’s a spectrum of assistance and not everyone needs all the intensive services. The key is to ‘right-size’ the interventions.” A partnership that Mercy Maricopa forged with the City of Phoenix Housing Department and Valley of the Sun United Way led to the creation of a program that now serves 275 individuals.

Housing programs

For its members with SMI, Mercy Maricopa provides permanent supportive housing services in a total of 3,400 housing units, including 907 subsidies for “scattered site” units funded by the state and 1,800 subsidies funded by federal McKinney Vento Homeless Assistance Grants through a partnership with a Housing and Urban Development (HUD) funded agency. Another 707 site-based units are subsidized by the state to provide housing in small apartment complexes and shared housing throughout Maricopa County. Eligibility is based, in part, on an individual’s diagnosis of a SMI, homeless status, and defined vulnerability.

The Comprehensive Community Health Program (CCHP) is the new program Mercy Maricopa established for adult plan members with mental health and substance use problems that do not meet the SMI threshold. CCHP is an integrated health home that addresses the housing needs of members by providing supportive services to assist them in obtaining and maintaining the housing of their choice through the Section 8 housing program. CCHP is built upon contributions from three partners: The City of Phoenix Housing Department contributes 275 federally funded Section 8 housing vouchers; United Way funds items and services, such as move-in kits,

repair costs, and furniture; and Mercy Maricopa Integrated Care provides Medicaid-covered permanent supportive housing-related services and supportive employment services.

Medicaid's role

By bringing Medicaid to the table, Mercy Maricopa was not only able to provide supportive housing-related services, but also helped the larger effort by fulfilling the “HUD service match.” That is, the value of Medicaid-covered housing-related services provided by Mercy Maricopa to support Medicaid members with mental health and substance disorders in their homes serves as the match required for HUD housing vouchers; in addition, some state-only Medicaid funds are used to acquire and/or subsidize housing for these individuals. In combination, these resources allow Medicaid members to receive individualized services in the community of their choice, ensuring that HUD funds are focused on expanding housing opportunities.

Mercy Maricopa provides a wide array of Medicaid-covered housing-related services through its housing programs, including housing navigation services and case management, that enrich the assistance available to individuals with different levels of need and in different types of housing arrangements. Covered services range from assistance with communication skills, financial management, budgeting, and securing benefits, to help developing meal preparation skills and public transportation skills, new tenant orientation and tenant's rights education (in conjunction with the Housing Provider), supportive counseling targeted toward housing permanency, and recreational/socialization opportunities and health and wellness activities.

Mercy Maricopa is pursuing additional partnerships with local housing authorities and is collaborating with Low-Income Housing Tax Credit developers. Its efforts to strengthen collaboration and data-sharing with community housing and homeless service providers are ongoing.

Results

While no outcome data are yet available for CCHP, preliminary findings from Mercy Maricopa's permanent supportive housing program for individuals with SMI show that admissions to psychiatric hospitals decreased by almost half (46 percent) between November 2014 and October 2015, and utilization of crisis services declined by one-third over the same period. In addition, during the same time period, housing retention increased by 3 percent and the number of members contributing to their rent increased by 4.2 percent.

Lessons learned

- **Partnerships among strangers.** Mercy Maricopa staff found that navigating and bridging the Medicaid and housing worlds can be challenging, but it can be done. When Mercy Maricopa first approached the City of Phoenix Housing Department, the notion of a partnership with Medicaid was foreign. For the joint project to work, developing relationships with city, state, and federal housing programs was an essential first step. Health and housing partners had to learn each other's unfamiliar “language” and understand how the program and policy frameworks and financing structures of Medicaid and housing programs differ. Appropriate roles had to be identified. CCHP partners had to find compatible approaches to providing member education and other services to CCHP-eligible individuals residing in permanent supportive housing.
- **Data challenges.** Data collection and sharing necessary for the design and effective implementation of services posed important challenges. While Mercy Maricopa had the Medicaid ID numbers and electronic

health records of its members, matching data to the HUD Homeless Management Information System proved challenging because that system collected different information. Further, HIPAA requirements prevent Mercy Maricopa from sharing health data with some of the housing service providers. Fortunately, the shuttered overflow shelter had the ability to generate and share data with Mercy Maricopa, which used the information to determine the needs of the population the shelter had been serving. These data helped Mercy Maricopa recognize that people with mental health and substance use disorders who are not classified as SMI need supportive housing services. In addition, a tool used in the housing community, called the Vulnerability Index - Services Prioritization Decision Assistance Tool, or VI-SPDAT, provided the health plan with an at-a-glance assessment of self-reported vulnerabilities, which includes hospitalizations, particular health conditions, and other issues, helping the plan ascertain which types of support individuals need most to avoid housing instability.

Discussion

The three initiatives profiled here –one launched by a city, one by a state, and one by a Medicaid MCO – provide examples of the collaborations possible between Medicaid and supportive housing programs that serve many of the same people. Looking at the implementation experience across the initiatives, a number of themes emerge.

Medicaid-housing integration efforts can be tailored to align with specific policy goals. The three integration efforts profiled in this brief were designed to advance their particular policy goals – to reduce chronic homelessness, reduce unnecessary institutionalization of people with disabilities, and provide appropriate supportive housing services for individuals with different degrees of mental illness. Strategies elsewhere have been designed to further other policy priorities, such as successful re-integration of justice-involved individuals into the community.

Partnerships entail operational challenges. Initiatives aimed at integrating Medicaid and housing face a number of challenges: fragmentation in the housing system, a complex health care system, differences in the Medicaid and housing administrative structures, and multiple funding streams with different rules. Medicaid programs may have to contract with multiple housing agencies and providers. Housing programs do not typically have a way to bill for health services, as is necessary to obtain Medicaid fee-for-service payment, and the cost and effort of developing the new systems may be significant. In addition, Medicaid may require credentialing of housing providers as a condition of enrollment in and payment by the program. Housing programs may also have concerns about whether Medicaid requirements would constrain the way they operate. Data issues, too, including limited availability of person-level data from housing programs and HIPAA prohibitions against sharing health data, among others, can impede efforts to target interventions. And clearly defining the roles of housing and health partners while also allowing for blending can be a delicate balancing act.

Early evidence suggests that Medicaid and housing programs working in concert can improve patterns of health care use and reduce Medicaid costs. Data from the three initiatives examined in this study showed Medicaid savings or reduced utilization of high-cost institutional care, in addition to gains in housing stability, income, and/or other outcomes. Interviewees pointed out that Medicaid returns on investment are affected by how programs are designed; by definition, there is greater potential for Medicaid

savings in initiatives targeted to high-risk populations with high costs. With regard to MCO-initiated partnerships, small scale is an issue in the return-on-investment calculus. Supportive housing residents are a small fraction of the Medicaid population and, in a local area, Medicaid enrollees who reside in supportive housing may be distributed across numerous MCOs. Therefore, the number of an MCO's Medicaid enrollees who might benefit from the plan's investment in housing-related services, and the associated savings potential, may be small in plans that are not Medicaid-focused.

Leadership and committed partnerships are essential. For many in the Medicaid and health care sphere, financing housing-related services as an investment in health is a new idea, and interviewees said that it was necessary to convince some in their institution's leadership to pursue this path. Both the health and housing officials we interviewed emphasized that figuring out who to approach and finding committed partners were critical to the success of their efforts. Citing the lack of familiarity and history between Medicaid and housing programs, interviewees commented on the importance of developing relationships. Uniformly, they stressed that "translation" was needed to bridge cultural, language, and bureaucratic differences between the two "worlds" to facilitate conversation and understanding before collaboration could proceed.

Conclusion

The growing emphasis on integrated care models that address not only health but also the social determinants of health, including housing, is spurring widespread innovation in state Medicaid programs and the delivery systems they rely on. In addition, states continue to rebalance their Medicaid long-term care programs, shifting away from institutional care in favor of community integration of seniors and people with disabilities. At the same time, millions of previously uninsured adults have gained Medicaid coverage, including many experiencing chronic homelessness or housing instability and many with mental illness and/or substance use disorders. The expansion of Medicaid coverage has increased both interest in Medicaid-housing integration and the potential impact of collaborations on both housing and health outcomes. Data from the recent annual 50-state Medicaid budget survey conducted by the Kaiser Commission on Medicaid and the Uninsured show that, in addition to 44 states that operate Money Follows the Person programs, 16 states implemented or expanded housing-related services outlined in the CMS Informational Bulletin in FY 2016 and/or plan to do so in FY 2017.¹¹ The sharpened focus in Medicaid on accountable systems of care that link payment to outcomes also augurs increasing activity in this area. The limited supply of affordable housing constrains the scale of Medicaid-housing initiatives, and the ability to expand these efforts will depend on increased availability of resources like LIHTC, housing vouchers, and other strategies to increase housing affordability.

Forging Medicaid-housing linkages will require new dialogues between agencies and programs with different administrative structures, financing systems, cultures, and operations, and with little previous interaction at the federal, state, or local level. Integrating Medicaid and supportive housing appears to have particular potential to improve health and housing outcomes and reduce avoidable costs for people with complex needs. Building the necessary bridges presents challenges, but partnerships on the ground today demonstrate that Medicaid and housing policy and program officials with shared purposes can devise strategies to meet them.

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Appendix: Summary of CMS Guidance on Medicaid Coverage of Housing-Related Services and Activities

The Centers for Medicare and Medicaid Services (CMS) issued an [Informational Bulletin](#) on June 26, 2015 that identifies and discusses the Medicaid options and waiver authorities that states can use to cover housing-related services and activities, and the extent of these authorities. The opportunities for states are summarized below, drawing directly from the CMS guidance. For more detailed information, readers should consult the Informational Bulletin directly.

SECTION 1915(C) HOME AND COMMUNITY-BASED SERVICES WAIVERS

Section 1915(c) home and community-based services (HCBS) waivers permit states to provide community-based LTSS for beneficiaries who meet an institutional level of care criterion. States can cover certain housing-related services under these Medicaid program waivers. Housing transition and tenancy sustaining services can be paid for as part of case management services under 1915(c) waivers. Environmental modifications to make community-based residential settings accessible can also be covered. In addition, the CMS guidance clarifies that, subject to specified criteria, states can receive federal Medicaid matching funds for the costs of certain Community Transition Services necessary for an individual leaving an institution to establish a basic household. These costs include, among others, security deposits required to obtain a lease, set-up fees for utilities, essential household furnishings, moving expenses, and services like pest eradication or preoccupancy cleaning necessary for the beneficiary's health and safety. Federal matching funds are available for these costs only if they are reasonable and necessary and only if the individual cannot meet the expenses and the services cannot be obtained from other sources.

SECTION 1915(I) HCBS STATE PLAN OPTIONAL BENEFIT

States have a regular state plan option (i.e., no waiver is required) under section 1915(i) to cover the same kinds of housing transition and tenancy sustaining services, environmental modifications, and Community Transition Services that can be covered under section 1915(c) HCBS waivers. However, because beneficiaries do not have to meet an institutional level of care to receive services under 1915(i), states can use this option to serve adults with behavioral health conditions and others who cannot qualify for services under a 1915(c) waiver. The ACA amended section 1915(i) to expand financial eligibility for services under this option, allow states to target 1915(i) services to specific populations, and expand the array of services states can cover under this state plan option. States that use this option must provide services statewide and cannot limit the number of people served.

SECTION 1915(K) COMMUNITY FIRST CHOICE (CFC) STATE PLAN OPTIONAL BENEFIT

Under this optional benefit, states can reimburse for person-centered home and community-based attendant services and supports in a home or community-based setting. Transition costs for individuals transitioning from an institution to the community and expenditures that increase an individual's independence or substitute for human assistance that would otherwise be necessary can be covered. These costs could also include security deposits for an apartment or utilities, bedding and basic kitchen supplies, first month's rent, and other one-time transition-related expenses.

TARGETED CASE MANAGEMENT (TCM) SERVICES

State plan TCM services are services furnished to “assist individuals in gaining access to needed medical, social, educational, and other services.” TCM is a specific service that is targeted to specific populations defined by the state. The Informational Bulletin clarifies that, as part of identifying a beneficiary’s total needs, TCM can include linking the person to needed housing resources, assistance with housing search, and assistance with identifying resources to support the participant in maintaining housing during a housing crisis.

SECTION 1915(B) MANAGED CARE WAIVERS

Most states have section 1915(b) waivers that permit them to provide and pay for state plan-covered services, including housing-related services, through managed care programs. The authority at section 1915(b)(3) permits states to use savings achieved under its 1915(b) waiver to provide additional services to beneficiaries enrolled in its managed care program. These savings may be used for housing-related services for enrollees to identify, transition to, and sustain their housing. The Informational Bulletin addresses state authorities to cover housing-related services in their managed care programs.

MONEY FOLLOWS THE PERSON (MFP) REBALANCING DEMONSTRATION

The MFP grant program provides states with enhanced federal Medicaid matching funds for 12 months for each Medicaid beneficiary who transitions from an institution to the community, and states can use MFP grant dollars for offer housing-related services to support transitions. Most of the 44 states with MFP programs are providing an array of housing-related services and activities, directly or through contracts with housing specialists, transition coordinators, case managers, and other providers. These services include state-level housing-related collaborative activities as well as individual housing transition services and tenancy sustaining services. Funding for MFP is set to expire in 2016, but any unused grant funds awarded in 2016 can be used through fiscal year 2020. Reauthorization of the program is uncertain.

SECTION 1115 DEMONSTRATION WAIVERS

Under section 1115 demonstration waivers, which must further the objectives of the Medicaid program and be approved by the Secretary of HHS, states are permitted additional flexibility in the design and operations of their Medicaid program. Section 1115 demonstrations can, and some do, include housing-related services described in the Informational Bulletin.¹² Demonstration waivers are generally approved for a five-year period and can be renewed for three more years. Federal spending under section 1115 demonstrations must not exceed expected federal spending in the absence of the demonstration.

Endnotes

- ¹ *Healthy People 2020 Topics and Objectives: Social Determinants of Health*, Office of Disease Prevention and Health Promotion, <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>. Also, *Healthy People 2020: An Opportunity to Address the Societal Determinants of Health in the United States*, Secretary's Advisory Committee on Health Promotion and Disease Prevention Objectives for 2020, U.S. Department of Health and Human Services, July 26, 2010, <http://www.healthypeople.gov/2010/hp2020/advisory/SocietalDeterminantsHealth.htm>
- ² *What Housing-Related Services and Supports Improve Health Outcomes among Chronically Homeless Individuals?* Rapid Evidence Review, 2016, AcademyHealth, <http://www.academyhealth.org/files/publications/files/publications/RER%255FHomelessness%255FHousing%255F2016%255FFinal.pdf>
- ³ Buchanan D et al., "The Health Impact of Supportive Housing for HIV-Positive Homeless Patients: A Randomized Controlled Trial," *American Journal of Public Health* 99 (Supplement 3), November 2009, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2774195/>; and Reid K et al., "Association between the Level of Housing Instability, Economic Standing and Health Care Access: A Meta-Regression," *Journal of Health Care for the Poor and Underserved* 19.4, November 2008, <http://search.proquest.com/docview/220586779/fulltextPDF/874CBF1D7D4F4CCOPQ/1?accountid=39486>
- ⁴ Raven M et al., "Medicaid Patients at High Risk for Frequent Hospital Admission: Real-Time Identification and Remediable Risks," *Journal of Urban Health* 86(2), March 2009, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2648879/>
- ⁵ Maqbool N et al., *The Impacts of Affordable Housing on Health: A Research Summary*, Center for Housing Policy, April 2015, http://www2.nhc.org/HSGandHealthLitRev_2015_final.pdf
- ⁶ Op. cit., Buchanan et al. Wollitski R et al., "Randomized Trial of The Effects of Housing Assistance on the Health and Risk Behaviors of Homeless and Unstably Housed People Living With HIV," *AIDS Behavior* 14(3), June 2010, <https://www.ncbi.nlm.nih.gov/pubmed/19949848>
- ⁷ Martinez T and M Burt, "Impact of Permanent Supportive Housing on the Use of Acute Care Health Services by Homeless Adults," *Psychiatric Services* 57(7), July 2006, <https://www.ncbi.nlm.nih.gov/pubmed/16816284>; Sadowski L et al., "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* 301(17), May 6, 2009, <https://www.ncbi.nlm.nih.gov/pubmed/19417194>; and *Home & Healthy for Good - Permanent Supportive Housing: A Solution-Driven Model*, January 2016 Progress Report, Massachusetts Housing and Shelter Alliance, <http://archives.lib.state.ma.us/bitstream/handle/2452/393621/ocn887735103-2016.pdf?sequence=1&isAllowed=y>
- ⁸ CMCS Informational Bulletin: *Coverage of Housing-Related Activities and Services for Individuals with Disabilities, Centers for Medicare and Medicaid Services (CMS)*, June 26, 2015, <http://www.medicare.gov/federal-policy-guidance/downloads/CIB-06-26-2015.pdf>.
- ⁹ *Medicaid and Permanent Supportive Housing for Chronically Homeless Individuals: Emerging Practices from the Field*, August 2014, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, <https://aspe.hhs.gov/sites/default/files/pdf/77116/EmergPrac.pdf>
- ¹⁰ *Medicaid Health Homes: An Overview*, Fact Sheet, CMS, September 2016, <https://www.medicare.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/hh-overview-fact-sheet-sep-2016.pdf>
- ¹¹ Smith V et al., *Implementing Coverage and Payment Initiatives: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2016 and 2017*, October 13, 2016, <http://kff.org/medicaid/report/implementing-coverage-and-payment-initiatives-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2016-and-2017/>
- ¹² See, for example, the Whole Person Care Pilots included in California's "Medi-Cal 2020" section 1115 demonstration waiver, available at <http://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx>. These pilot target particularly vulnerable groups of Medi-Cal beneficiaries who have been identified as high users of multiple systems and continue to have poor health outcomes. They involve collaborative leadership and systematic coordination among public and private entities, which may include housing entities, with the goal of providing comprehensive coordinated care for the beneficiary resulting in better health outcomes.