CHCS Center for Health Care Strategies, Inc.

POLICY FACT SHEET

Medicaid-Financed Services in Supportive Housing for High-Need Homeless Beneficiaries: Emerging Options

IN SUMMARY

- The Medicaid expansion under the Affordable Care Act (ACA) will provide new insurance coverage to the estimated 1.2 million individuals in the U.S. who are homeless, including the roughly 110,000 who are chronically homelessness and more likely to have chronic and complex health conditions.
- Medicaid-financed care management in supportive housing for high-risk homeless Medicaid beneficiaries could yield a significant return on investment from reduced hospitalizations and emergency department use.
- Growth in Medicaid managed care for these high-need 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.
- States could 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.

Homelessness and housing instability are significant impediments to health care access and improved health for people with complex conditions, often resulting in high utilization of expensive inpatient and crisis services. Supportive housing can improve their health outcomes while reducing costs.[1]

By providing stable affordable housing coupled with "high touch" supports that engage and connect people with chronic health conditions to a network of comprehensive primary and behavioral health services, supportive housing can help increase survival rates, reduce inpatient utilization, foster mental health recovery, and reduce alcohol and drug use among formerly homeless individuals.[2] With interagency support, state Medicaid programs could implement "high touch" case management in supportive housing for low-income adults in 2014.

Medicaid and the 2014 Expansion

Estimates of the percentage of people living in homelessness who are currently eligible for Medicaid vary, and depend on a state's established eligibility policies. Most agree that relatively few single homeless individuals are covered, except in states that have already enacted voluntary coverage expansions (e.g., New York, Oregon).

In 2014, however, virtually all of the estimated 1.2 million individuals in the U.S. who are homeless will be among the approximately 16-20 million people who will gain Medicaid eligibility under the Affordable Care Act (ACA). States that have previously expanded Medicaid coverage to this population report that many of the new enrollees will have significant unmet health needs and high health costs. This was illustrated in a study of the Oregon Health Plan where the childless adult population had more complex health needs and higher utilization than the adults with children.[3] The complex health needs are likely even greater among people who are homeless.

Care Management for Newly Eligible Medicaid Beneficiaries Who Are Homeless

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. Providing care management services in supportive housing can result in:

- Reduced utilization of crisis and inpatient services;
- Control of Medicaid cost growth;
- Benefits to other public systems (e.g., corrections); and
- Better health care and life outcomes for chronically homeless individuals.[4]

There are a number of ways that states can fund care management services within the supportive housing environment under Medicaid program rules. As much as 85 percent of care management provided in supportive housing environment is potentially reimbursable under the Medicaid program.[5] The most promising state options are:

1. **New Health Home State Plan Option**: This new option under the ACA provides states with 90 percent federal match 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 is promising. Although "homelessness" *per se* is not a permissible targeting criterion for health homes, intensive care management linked to affordable housing could be part of a broader state health home strategy.

   In New York, for example, much of the homeless population is already Medicaid eligible due to prior

coverage expansion. The state is currently rolling out a major delivery system reform through the health home option and is requiring the networks of health home providers to include partnerships with housing agencies.

2. **Managed Care**: Medicaid managed care organizations (MCOs) can pay for care management services in supportive housing projects. As long as they stay within their capitation rates, MCOs have the flexibility to add services above the basic statewide Medicaid service package to address particular needs of their enrollees. In most states, currently only a small percentage of supportive housing residents are Medicaid eligible and they may be enrolled in different managed care plans, decreasing the likelihood that a particular plan will make this investment. The ACA, however, will dramatically increase Medicaid eligibility among individuals living in supportive housing. Accordingly, plans are likely to have far greater financial incentive to make such investments in the future.

   Massachusetts, for example, uses managed care contracting to direct special attention to the provision of housing-based services. The Community Support Program for People Experiencing Chronic Homelessness is a benefit provided through the Massachusetts Behavioral Health Partnership (led by Value Options). The plan contracts out care management linked to affordable housing on a $17 per diem case rate, which translates to a $368 per member per month.

Other potential options include coordination via home- and community-based 1915(i) waivers or state plan options, such as rehabilitation and targeted case management services.

Policy Considerations

States can pursue a variety of models to finance care management in a supportive housing setting. Additional issues for states to consider include:

- States and local housing providers will need to ensure that supportive housing is targeting high-need, high-cost, chronically homeless individuals in order to achieve future cost savings.
- States will need to determine which Medicaid payment methods to employ in reimbursing services in a supportive housing environment.
- Technical assistance and/or new organizational configurations will be needed to help bridge the gap between current supportive housing capacity and Medicaid requirements (e.g., billing, quality reporting).
- Systems and methods are needed for tracing and managing costs for people who are chronically homeless.

In conclusion, developing strategies to leverage Medicaid services to address the health needs of supportive housing residents represents a promising investment for federal, state, and local governments, particularly given the upcoming Medicaid expansion. In doing so, states can potentially improve health outcomes for an at-risk population, reduce the cycle of homelessness, and contain Medicaid costs.

FOR MORE INFORMATION

Read the policy brief, *Medicaid-Financed Services in Supportive Housing for High-Need Homeless Beneficiaries: The Business Case,* coauthored by the Center for Health Care Strategies and the Corporation for Supportive Housing and supported by the Robert Wood Johnson Foundation. The brief outlines the rationale for states to consider designing Medicaid-financed, supportive housing-based care management services to improve care for high-need beneficiaries who are homeless. Available at www.chcs.org.

[1] *Supportive Housing Research FAQs: Is Supportive Housing Cost Effective?* Corporation for Supportive Housing, November 2006. Available at http://documents.csh.org/documents/policy/FAQs/CostEffectivenessFAQFINAL.pdf.
[2] M.E. Larimer, D.K. Malone, M.D. Garner, et al. (2009). "Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problems." *The Journal of the American Medical Association, 301(13), 1349-1357.*
[3] S.G. Haber, G. Khatutsky, and J.B. Mitchell. "Covering Uninsured Adults through Medicaid: Lessons from the Oregon Health Plan." *Health Care Financing Review.* Vol 22, Number 2, 2000.
[4] *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.
[5] "Understanding Supportive Housing Services and Potential Medicaid Reimbursement, Connecticut." Corporation for Supportive Housing, 2012. Available at http://www.csh.org/resources/csh-medicaid-crosswalk-connecticut.