



Strategies to Strengthen Health and Housing Partnerships Through Medicaid to Improve Health Care for Individuals Experiencing Homelessness

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On a single night in January 2016, nearly 550,000 people experienced homelessness in the United States.^{1, 2} These individuals are disproportionately impacted by chronic medical and behavioral health conditions,^{3, 4} and many lack health insurance or a usual source of care.^{5, 6} Permanent supportive housing programs (see **Text Box**) are critical to improving health outcomes for individuals experiencing homelessness while simultaneously reducing medical and societal costs. Partnerships between state Medicaid agencies, safety net providers (particularly Health Care for the Homeless programs), and the housing sector are pivotal in ensuring these services are available and accessible to individuals who need them.

This brief explores how state Medicaid agencies have utilized a variety of federal authorities and delivery systems to increase access to supportive housing services and highlights important implementation considerations. For additional information about homelessness in the United States and additional background information on the link between health and housing and the roles for Medicaid and safety net providers in serving individuals experiencing homelessness, please see **Appendix A**.

Permanent Supportive Housing and Housing First

Permanent Supportive Housing (PSH) programs combine affordable, community-based housing with a range of health care and community support services for individuals with serious mental illnesses or other disabilities who need support to live stably in their communities.¹ Housing arrangements include: *single-site* (PSH units are situated within a single building or complex); *scattered-site* (PSH units are located throughout a community); and *set-asides* (a specific number or percentage of units in a building or complex are reserved for individuals receiving PSH services).² Unlike institutional settings of care, PSH confers ordinary tenancy rights through leases or other legal agreements.³

Housing First is an evidenced-based PSH model that prioritizes housing above meeting specific residency requirements, such as sobriety or treatment mandates. This program's central tenet is that everyone can achieve stability in permanent housing directly from homelessness and that stable housing is the foundation for pursuing other health and social services goals.⁴ Service providers work closely with individuals to meet their health and psychosocial needs. Although not a condition of tenancy, individuals with a substance use disorder are encouraged to engage in specialty treatment and peer-based recovery services.⁵

The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) developed a **Permanent Supportive Housing Evidence-Based Practices Knowledge Informing Transformation (EBP KIT)** to support state leadership, service providers, and other key stakeholders in developing and implementing effective PSH programs.⁶

Note: Definitions abridged/adapted from U.S. Interagency Council on Homelessness website (see sources below).

¹<https://www.usich.gov/solutions/housing/supportive-housing>; ²<https://www.usich.gov/solutions/housing/supportive-housing>; ³<https://aspe.hhs.gov/report/primer-using-medicaid-people-experiencing-chronic-homelessness-and-tenants-permanent-supportive-housing> (Section 3.1.); ⁴<https://www.usich.gov/solutions/housing/housing-first>; ⁵<https://aspe.hhs.gov/report/primer-using-medicaid-people-experiencing-chronic-homelessness-and-tenants-permanent-supportive-housing> (Section 3.1.); ⁶ Each section of the PSH EBT KIT are available for download as individual PDF files at <http://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4510>.

State Strategies to Better Integrate Health and Housing in Medicaid

Section 1115 Demonstrations

Section 1115 demonstrations provide states with significant flexibility to test novel payment and delivery models that meet the Centers for Medicare & Medicaid's (CMS') objectives of increasing coverage and access, improving quality and outcomes, and increasing efficiency.⁷ Many states have used Section 1115 authority to implement and expand access to supportive housing services.^{8, 9}

Increased access to housing and supportive services is an explicit goal of **California's** Medi-Cal 2020 Demonstration.¹⁰ High-risk, high-utilizing individuals at risk of or experiencing homelessness are a target population for Whole Person Care (WPC) pilots, designed to better coordinate medical, behavioral health, and social services.¹¹ WPC pilot sites focusing on homelessness are expected to collaborate with local housing authorities, Continuums of Care (local/regional entities that coordinate housing and related support services¹²), and other appropriate community-based providers and organizations. Allowable interventions include tenancy-based care management services including housing transition services.¹³ As of November 2016, 11 WPC pilots offered housing-related services.¹⁴

Similarly, **Washington** prioritized supportive housing services in its 1115 demonstration approved last year. Community Transition and Community Support services are included through the Foundational Community Supports program, which also includes a supportive employment benefit.¹⁵ In **Hawaii**, supportive housing services are included in specialized behavioral health services available through the QUEST Integration Medicaid Section 1115 Demonstration.¹⁶

State Delivery System Reform Incentive Payment (DSRIP) programs, authorized under the 1115 demonstration authority, have also led to increased access to housing-related services. States can design DSRIP waivers that require participating providers to take on a myriad of delivery system reforms and/or quality improvement projects.¹⁷ **New York**, for example, included transitional supportive housing services as an optional system transformation project for participating provider groups. Hospitals in these participating provider groups were required to partner with supportive housing and home care providers.¹⁸

Providers in **Texas** have also leveraged DSRIP to better serve individuals experiencing homelessness, and 19 Texas DSRIP projects included individuals experiencing homeless in their target populations.¹⁹ The City of Houston partnered with the local Health Care for the Homeless (HCH) program, a community-based homeless service provider that provides clinical case management services and an affordable housing provider, to create an integrated care system for chronically homeless individuals with complex medical and behavioral health issues. Individuals participating in this Housing First program were given top priority for housing vouchers and subsidies.^{20, 21} Similarly, the City of Austin's Health and Human Services Department expanded Assertive-Community Treatment services for recently-housed individuals with co-occurring medical, psychiatric, and substance abuse conditions.²²

Home and Community-Based Services

As illustrated in Table 2 in **Appendix A**, state Medicaid agencies can cover housing-related activities and services using a variety of home and community-based services (HCBS) waiver and state plan options. **Louisiana's** Permanent Supportive Housing program showcases how states can leverage different Medicaid authorities to support a single supportive housing program. The Louisiana Department

of Health administers the program in partnership with the state's housing agency, and the program is heralded as "the nation's first cross disabilities [permanent supportive housing] program."²³ Most funding for housing-related support services is authorized through five different 1915(c) HCBS waivers and the state plan²⁴, with some additional funding streams made available by federal agencies, including the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration (SAMHSA), the U.S. Department of Veterans Affairs, and the U.S. Department of Housing and Urban Development (HUD).²⁵ Louisiana Medicaid opened specific billing codes for the following tenancy support services:

- 1915(c) waiver services (not limited to face-to-face time):
 - pre-tenancy and/or tenancy crisis services
 - tenancy maintenance services
- State plan behavioral health services (limited to face-to-face time, but modifier increases rate when delivered as a PSH service):
 - community psychiatric supportive treatment
 - psychosocial rehabilitation.^{26, 27}

According to a 2012 publication by the Technical Assistance Collaborative, Inc., the Louisiana Permanent Supportive Housing program reduced Medicaid costs for participants by 24 percent.²⁸ The savings were primarily attributable to reductions in institutional costs.

Managed Care Organizations

State Medicaid programs' reliance on managed care delivery systems continues to grow. As of July 2016, 39 state Medicaid programs held risk-based contracts with managed care organizations (MCOs),²⁹ and managed care enrollment accounted for at least 75 percent of all beneficiaries in 28 of those states.³⁰ MCOs can be critical partners for states and providers working to better connect Medicaid beneficiaries experiencing homelessness with housing and housing-related support services. An issue brief written by UnitedHealthCare Community & State for the National Health Care for the Homeless Council identified collaboration opportunities between Medicaid MCOs and HCH grantees in eight common goals, including addressing social determinants of health, ensuring appropriate utilization, and improving quality outcomes.³¹

In **Minnesota**, Hennepin Health, a county-administered Medicaid MCO that leads a local safety-net accountable care organization partnership,³² has been particularly successful in serving individuals experiencing homelessness. Hennepin Health has created a Social Services Navigation Team that identifies individuals experiencing unstable housing and assists to secure permanent housing. Hennepin Health leverages county-managed contracts with local housing providers to prioritize housing for individuals identified by the Social Service Navigators.

Data from 2012 through mid-2014 shows that individuals participating in Hennepin Health's housing navigation program experienced:

- A 16 percent decline in inpatient hospital admissions;
- A 35 percent decrease in emergency department visits;
- An 18 percent drop in psychiatric emergency department visits;
- And a 21 percent increase in outpatient clinic visits.³³

Taken together, these results indicate these collaborative housing services:

- Improved individuals' health so hospital services were not required;
- Reduced unnecessary hospital utilization by shifting non-emergency care to outpatient settings;
- Increased access to outpatient services to address unmet health care needs;
- Or some combination thereof.

Accountable Care Organizations

As of June 2017, 10 states had active Medicaid accountable care organization (ACO) programs³⁴ and 12 more states and the District of Columbia were working to develop ACOs.³⁵ Generally, value-based payment arrangements that include upside and/or downside risk to the participating providers give ACOs a financial incentive to address non-medical needs that can affect health care-related costs. A recent study identified housing as one of the most common non-medical issues addressed by ACOs, with ACO staff helping to identify housing options, working with housing agencies to determine availability, and assisting individuals in completing the necessary paperwork.³⁶ Some ACOs have successfully negotiated policy changes with housing providers, including transitioning to a Housing First approach for individuals with substance use disorders and designating beds for homeless individuals discharged from a hospital.³⁷

In 2015, the Camden Coalition of Healthcare Providers, one of three certified **New Jersey** Medicaid ACOs, launched a scattered-site Housing First initiative serving 50 individuals who had high utilization of the local health care system.³⁸ Participating individuals receive wrap-around services from a local behavioral health service provider, and partnerships with three non-profit community development organizations helped secure participation from landlords and property management companies.³⁹ Financial support came from a mix of public and private sources, including housing vouchers from the state housing agency and funding from the state budget (including block grant funds), a county-funded trust fund established to address homelessness, a local philanthropic foundation, and a local academic medical center.⁴⁰

Health Homes

The Medicaid Health Home State Plan Option⁴¹ may be a useful authority to better connect individuals experiencing homelessness with housing-related services and supports.⁴² Health homes are designed to ensure individuals receive whole-person, integrated care, including comprehensive care management, care coordination, and referral to relevant community and social support services as necessary and appropriate.⁴³ States have significant flexibility to determine which populations are eligible for health homes services,⁴⁴ but regardless of which combination of medical or behavioral health conditions are used, it is likely that a significant proportion of Medicaid-eligible individuals experiencing homelessness would meet health home participation criteria.

In 2013, the **California** legislature explicitly directed the California Department of Health Care Services (DHCS), which administers the state's Medicaid program, to include chronic homelessness when prioritizing enrollment in a health home program. The legislation also required health homes to link individuals experiencing homelessness or housing instability to supportive housing services.⁴⁵ Housing is a key feature in DHCS' health home model, and it incorporates housing navigators who serve on multi-disciplinary care teams.⁴⁷ California's health home state plan amendment is still pending approval, but DHCS has asked to implement its health home model under the state's Section 1115 demonstration authority. As of April 2017, DHCS anticipates program implementation rolling out geographically in three phases beginning in July 2018.⁴⁸

In addition to building housing-related services in a health home program, states may be able to identify grant opportunities or other state-only funding to connect health homes with supportive housing providers. For example, state leaders in **New York** capitalized on their Medicaid transformation efforts by providing grant support to foster partnerships between health homes and supportive housing providers. The state’s Request for Applications stipulated that funds must be used to “[provide] housing and/or services that facilitate the provision of housing to a health home member and their ability to remain stably housed.”⁴⁹ (See **text box** for examples of permissible uses of funds.) The New York State Department of Health awarded nearly \$4 million to 10 supportive housing providers across the state in this pilot in 2014,⁵⁰ and all 10 contracts were renewed for a second year.⁵¹

Permissible Use of Grant Funds in the New York Supportive Housing Health Home Pilot Project

- Services/staff to assist in identifying and locating health home members
- Services/staff to assist in navigating and identifying housing options, including assistance in completing housing applications
- Services/staff helping the health home member remain stably housed, including housing/employment counseling
- Care planning coordination services
- Rental subsidies and other occupancy costs

Source: <https://www.health.ny.gov/funding/rfa/inactive/1310310853/1310310853.pdf>, p.7.

Discussion: Key Considerations for Implementation

Medicaid Authorities and Services

The old adage, “if you’ve seen one Medicaid program, then you’ve seen one Medicaid program,” holds true when exploring how states can improve coverage and access for individuals experiencing homelessness. States may find that certain authorities are a better fit given:

- The structure of their current Medicaid programs;
- Their current and future state priorities;
- And availability of financial and staff resources.

Demonstrations and Waivers. Each Medicaid authority that states can utilize to better integrate health and housing comes with its own trade-offs. For example, state waivers or demonstrations may allow greater flexibility to waive federal requirements (e.g., statewideness), but these are typically time-limited and include budget- or cost-neutrality requirements. Additionally, some waivers restrict who can receive the covered services. For example, individuals receiving services under a 1915(c) home and community-based service waiver must meet the state’s eligibility for receiving institutional services.⁵² Conversely, while states may be able to leverage state plan options to serve individuals who do not meet an institutional level of care or avoid budget-neutrality requirements, states may not be permitted to impose geographic or enrollment restrictions under these authorities.

[A technical assistance tool](#) available on the CMS website provides an overview of the specific flexibility and limitations that accompany individual Medicaid authorities.⁵³ Policymakers may also be interested in a [white paper](#) that the Corporation for Supportive Housing (CSH) developed for the state of Washington that explores the pros and cons of using different authorities.⁵⁴ CSH developed

that resource along with [seven other state crosswalks](#) that studied Medicaid coverage of tenancy support services in Arizona, Colorado, Connecticut, Illinois, North Dakota, New Hampshire, and Pennsylvania.⁵⁵

It is important to note that not all costs associated with housing-related waiver services are eligible for federal financial participation. The Department of Health and Human Services (HHS) Office of the Inspector General (OIG) determined the Pennsylvania Department of Welfare (DPW, now the Department of Human Services) could not claim a federal match for administrative costs related to its Regional Housing Coordinator Initiative that helped coordinate 1915(c) waiver services. The state argued that the technical assistance provided by the program was directly related to administration of the Medicaid program, but OIG concluded the costs were indirect and recommended that DPW refund any federal administrative costs related to the program.⁵⁶

Managed Care. As noted in an [issue paper](#) prepared by the Office of the Assistant Secretary for Planning and Evaluation, some Medicaid MCOs may not have the experience or expertise to meet the needs of individuals experiencing homelessness. For example, telephonic case management programs may not be appropriate for a population with limited access to a telephone.⁵⁷ Shortly after Medicaid expansion went into effect in 2014, some health centers serving individuals experiencing homelessness reported barriers in working with managed care plans, including provider assignment algorithms that disrupted existing provider-patient relationships and differing utilization management policies across plans.⁵⁸

On the other hand, some MCOs—particularly those that administer specialty plans for conditions that disproportionately affect individuals experiencing homelessness—may be ideally positioned to take on a larger role in supportive housing programs. In **Massachusetts**, the Massachusetts Behavioral Health Partnership (MBHP), which administers the behavioral health carve-out for individuals enrolled in the state’s primary care case management program, has played an integral role in Massachusetts’ Community Support Program for People Experiencing Chronic Homelessness. According to a case study published in 2016, leveraging MBHP allowed the state’s Medicaid agency to cap enrollment in the pilot, bundle payment for community support services, and reduce administrative burden for supportive housing providers. Plan data suggests the program has produced an average annual net savings of more than \$10,000 for each individual receiving housing.⁵⁹

While balancing MCOs’ ability to establish and maintain their provider networks, state Medicaid agencies may wish to explore opportunities during procurement to ensure that prospective MCOs have the capacity to serve individuals experiencing homelessness. States could require MCOs to partner with specific community support providers to provide certain services for specific populations. While not specific to individuals experiencing homelessness, **Ohio** took this approach as part of its Financial Alignment Initiative for dually-eligible Medicare-Medicaid beneficiaries. In its three-way contract between the state, CMS, and participating MCOs, the Ohio Department of Medicaid required health plans to contract with Area Agencies on Aging to coordinate HCBS waiver services for individuals aged 60 and older.⁶⁰ State Medicaid leadership may wish to consider setting similar partnership expectations between MCOs and Continuums of Care or other housing partners to ensure comprehensive coordination of services for individuals experiencing homelessness.

Additionally, states may wish to capitalize on the 1915(b)(3) authority that specifically allows a state Medicaid agency to cover additional services using the savings accrued by the managed care program. **Michigan** included a number of housing-related services under this authority in its Managed

Specialty Services and Supports Waiver for individuals with mental health or developmental disabilities, including environmental modifications, housing assistance, and skill-building assistance.^{61, 62}

Health Homes. States have a unique financial incentive under the health home state plan option—eight quarters of enhanced federal match (90 percent) for health home services. States are also allowed to phase-in or limit health home services based on geography, which would allow a state to target specific counties or regions with the greatest number of individuals experiencing homelessness and/or areas of the state where providers are best equipped to serve homeless populations. One caveat for participating state Medicaid programs is they must ensure there is no duplication of services between health homes and other authorities, including targeted case management programs, HCBS waiver services, or care management services provided by managed care plans.

Tenancy Support and Respite Services. In reviewing the literature and conducting key informant interviews, two key points regarding benefit design stand out. First, program leaders in **Louisiana** recognized the importance of covering tenancy support services as a standalone benefit rather than including them in a broader case management benefit, given most case managers do not have the capacity to address tenancy crises.⁶³ States may find 1915(c) and 1115 authorities particularly useful for building in a specific tenancy support benefit.⁶⁴

Second, medical respite services, which combine short-term housing with integrated medical and case management services for individuals discharged from a hospital, have demonstrated success in improving health and housing outcomes and reducing costs for individuals experiencing homelessness.⁶⁵ There were 80 known respite programs operating in 2016, but only 18 percent of those included financing from public insurance programs.⁶⁶ In addition to authorizing respite services through 1915(c) and 1115 authorities, state Medicaid agencies may wish to work with their Federally Qualified Health Centers (FQHCs) to include respite services⁶⁷ in their scopes of services.⁶⁸ FQHCs may be an underutilized source of respite care, as only one-third of respite programs operating in 2011 were operated by an FQHC.⁶⁹

In **Minnesota**, the HCH program in Hennepin County provides medical respite services,⁷⁰ however, some individuals who qualified for medical respite have demonstrated a preference to return to more-familiar shelters that may not be able to meet their medical needs.⁷¹

Housing Stock

Perhaps the most significant barrier Medicaid agencies and safety-net providers face in connecting individuals at-risk of or experiencing homelessness with housing is the national shortage of affordable housing units. While 2013 data from HUD showed there were roughly 91 affordable, available, and adequate units available for every 100 low-income renters, the housing stock for the lowest-income renters (those between 0 to 30 percent of an area's median income) was significantly lower, with just 39 available units per 100 renters. About 12 percent of those units were classified as having severe deficiencies, which may include significant plumbing, heating, electrical, or upkeep problems.⁷² A recent report published by the National Low Income Housing Coalition using 2015 data found similar housing shortages for extremely-low income households, with a total national shortfall of nearly 7.4 million units.⁷³ In **Florida**, housing availability for extremely-low income renters in some counties was as low as 4 units for every 100 renters, and affordable housing shortages for these renters was described as, “the root cause of homelessness.”⁷⁴

Medicaid agencies have limited opportunities to improve housing stock. In addition to restrictions on paying monthly rental or mortgage costs, federally-matched Medicaid funds cannot be used to fund the capital or brick-and-mortar costs associated with new construction or housing rehabilitation.⁷⁵ **New York** sought to reinvest a portion of its federal cost savings to fund capital development, but CMS denied this portion of the state's waiver request.⁷⁶ However, the New York State Department of Health, which houses the state Medicaid agency, has successfully used state-only savings from the Medicaid Redesign process to fund capital-funding initiatives, including \$150 million for the Supportive Housing Opportunity Program⁷⁷ and \$63.5 million for the Homeless Housing and Assistance Program, the latter of which includes a \$5 million set-aside for projects serving individuals experiencing homelessness with HIV/AIDS.⁷⁸

Prioritization. It is natural for Medicaid agencies and safety net providers to prioritize housing units for high-cost, high-need enrollees. For example, the Camden Coalition's Housing First initiative prioritizes super-utilizers (i.e., individuals with two or more inpatient hospital admissions within a six-month period or excessive emergency department use) with two or more diagnosed chronic health conditions.^{79, 80} However, local public housing authorities and housing providers that accept vouchers may prioritize differently, using duration of homelessness or income-level.⁸¹ HUD encourages supportive housing providers to prioritize both history of homelessness and the severity of service needs with longer histories of homelessness receiving higher ranking than severity of service needs.⁸²

With limited resources, it may be necessary for state Medicaid agencies and safety net providers to work with their housing partners to develop shared prioritization criteria when housing individuals experiencing homelessness. Depending on the housing stock and the covered services—along with the specific Medicaid authority used—state policymakers may need to decide whether to prioritize programs that serve individuals who have already experienced chronic homelessness or focus efforts on preventing new cases of homelessness for housing-insecure Medicaid enrollees. It is important to acknowledge that these two approaches are not necessarily mutually exclusive.

Cross-Agency and Cross-Sector Partnerships

As illustrated by Louisiana's consolidated permanent supportive housing program, strong linkages between state health and housing agencies, service providers, and other key stakeholders is integral to improving care for individuals experiencing homelessness.

Similar to Louisiana, state health and housing agencies in **Ohio** have built strong relationships over the past decade. In 2007, Gov. Ted Strickland established the Interagency Council on Homelessness and Affordable Housing, which brought together 16 state agencies and 8 advocacy groups.⁸³ The council developed a statewide policy framework for permanent supportive housing programs, including shared goals, definitions, and program criteria.⁸⁴

Facilitating collaboration and establishing financial partnerships with the private sector may also benefit health and housing initiatives, particularly in states facing budget shortfalls. In 2013, the **Texas** Legislature authorized the Health Community Collaborative, a grant program specifically designed to improve coordination and collaboration between the public and private sectors to better serve individuals with mental health conditions experiencing homelessness.⁸⁵ State grants were matched dollar-for-dollar with private funds.⁸⁶

The Corporation for Supportive Housing has developed a [strategic guide](#) to help establish and strengthen partnerships between health centers and supportive housing providers.⁸⁷ State Medicaid officials working to strengthen these relationships as part of their housing-related initiatives may find this tool useful. Some of the lessons and processes described in the guide (e.g., understand your partners, create a shared vision) are transferrable for engaging colleagues across state agencies.

Facilitators for Success. While securing buy-in from leadership is critical in these endeavors, the value of building relationships across mid-level and program staff should not be underestimated. Governors, cabinet secretaries, and agency directors are often affected by term limits and have limited bandwidth for a single initiative. Program staff tend to have longer tenures and more focused responsibilities and may be better positioned to sustain focus and progress across administrations.⁸⁸ It is important to remember that these initiatives must also meet landlord and housing developer needs, as empty units or slow placement may deter their participation or result in fewer units for permanent supportive housing programs.⁸⁹

To the extent allowable under state and federal law, state agencies and health centers may also wish to explore opportunities to develop and enter into data use agreements to share data across health and housing partners. Better coordination of state Medicaid, public health, and housing datasets may improve each agency's ability to identify, engage, and serve eligible populations. For example, the **Utah** Department of Workforce Services (DWS) began matching data from the state's homeless management information system (HMIS)⁹⁰ with the state's Medicaid eligibility system.⁹¹ In a 2016 report, DWS noted that matching HMIS data with various state and local entities (including a mental health hospital and county jail) helped identify system overlaps and opportunities to better coordinate services.⁹² Similarly, data warehouse systems that compile health and housing data from multiple sources may be particularly useful for policymakers and providers.⁹³ For example, the **Ohio** Human Services Data Warehouse began by consolidating HMIS data from local Continuums of Care, and the program was designed to allow cross-system analysis to "develop a holistic picture of homelessness in Ohio," including the ability to analyze service utilization trends and assess the impact of supportive housing programs to inform policymaking.^{94, 95}

Ultimately, strong cross-sector health and housing partnerships facilitate improved service coordination, and individuals experiencing homelessness benefit from *coordinated entry* processes that promote a "no wrong door" approach to ensure individuals receive necessary health and housing services regardless of where or when they enter into the system.⁹⁶

Challenges. One challenge that is common for any cross-stakeholder initiative is that different groups do not always "speak the same language." Each sector has its own unique set of definitions and acronyms, and the experts interviewed for this brief routinely noted that it is critical for level setting to occur early in relationship development.

As noted earlier, one example of misalignment is how different federal agencies define homelessness, which can affect eligibility for some programs and services. Specifically, HUD requires individuals to have a qualifying disability to be considered chronically homeless, as illustrated by the first question on HUD's Office of Community Planning and Development's flowchart in determining chronic homelessness.⁹⁷ With HHS using a broader definition that does not take disability into account,⁹⁸ health centers may find themselves in a position of serving a subset of individuals experiencing homelessness who may not qualify for HUD programs.

Supportive housing programs that braid or blend funding streams can simplify eligibility issues for providers, although states should not underestimate the administrative complexity associated with program compliance.⁹⁹ Additionally, as with other initiatives designed to address social determinants of health, there are potential economic considerations at play where savings may not accrue in a way that tracks with each partner's share of the costs. This phenomenon, sometimes referred to as the *wrong-pocket problem*, can occur both within and across agencies and sectors, across levels of government, and even across time (an important consideration for state legislators as they develop annual and biennial budgets).¹⁰⁰ An Urban Institute [issue brief](#) explores the wrong-pocket program and offers innovative *pay-for-success* financing strategies that may help health and housing partners overcome these budgeting challenges.¹⁰¹

Lastly, there remains the question of how stigma affects housing partners' participation in supportive housing programs. Housing First initiatives have grown, but policymakers still face resistance when securing new housing units for justice-involved individuals or those living with a substance use disorder. Policymakers and stakeholders may be able to address stigma by engaging housing partners in cross-sector behavioral health integration training opportunities. In **Texas**, local public health authorities, housing providers, and community partners participated in Mental Health First Aid training¹⁰² to better understand individuals' behavioral health needs and decrease stigma.¹⁰³ Some supportive housing providers may be hesitant to house some special populations, although one expert interviewed for this brief noted this is more likely to result from capacity limitations due to budget constraints than from stigma.¹⁰⁴

Education and engagement on the success of permanent supportive housing programs can be important tools to recruit and maintain housing partnerships. One study of a single-site Housing First initiative serving individuals experiencing chronic homelessness with an alcohol use disorder found that 77 percent of the participants maintained housing for two years. Nondrinkers were more likely to return to homelessness than active drinkers, though authors noted the results may have been influenced by the "fit" of the program for each participant, and outcomes may have been reversed in an abstinence-based program.¹⁰⁵

Justice-Involved Populations and Homelessness

Justice-involved populations, many of whom are Medicaid-eligible and disproportionately experience homelessness, may be particularly impacted by federal eligibility requirements. Federal housing regulations count institutional stays (which includes correctional facilities) of greater than 90 days as a "break" in homelessness.¹ Depending on their sentence(s) over a three-year period, a justice-involved person who has experienced homelessness may leave a correctional facility ineligible for certain housing programs due to the fact that they were 'housed' while incarcerated.

Barriers persist in healthcare as well. In **Minnesota**, justice-involved populations have faced issues securing health coverage upon release, and challenges related to the state's health care marketplace has exacerbated this problem for individuals leaving incarceration.² Additionally, local law enforcement policies that effectively criminalize actions taken when experiencing homelessness (e.g., sleeping in public places) can exacerbate these challenges.³ State Medicaid officials and safety net providers may wish to explore opportunities for engaging or strengthening partnerships with criminal justice partners as part of their supportive housing efforts to help mitigate and address these challenges.

Sources: ¹<https://www.hudexchange.info/resources/documents/Defining-Chronically-Homeless-Final-Rule.pdf>; ²Personal Communication with Julie Bluhm; ³<http://www.nhchc.org/wp-content/uploads/2011/09/Criminal-Justice-2012.pdf>.

Federal Support and Resources. In recent years, federal partners have increasingly recognized the importance for cross-pollination within and across state agencies and community partners. Two specific programs encouraging collaboration stand out, one administered by HUD and the other by CMS.

HUD's Healthcare and Housing (H2) System Integrations Initiative provided technical assistance to communities in 20 states. States' action plans available on HUD's website may provide inspiration for work in other states,¹⁰⁶ and a public H2 toolkit may also support state efforts.¹⁰⁷ Resources of interest in the toolkit include a tool that helps states develop a Medicaid supportive housing benefit,¹⁰⁸ an overview of innovative funding strategies,¹⁰⁹ and an overview of model implementation strategies.¹¹⁰

Housing-related services and partnerships were also a key component of the CMS Innovation Accelerator Program's (IAP) Community Integration functional area. [Webinar materials](#) are available on CMS's website,¹¹¹ and CMS recently launched a new State Medicaid-Housing Agency Partnerships Track through IAP.¹¹²

Rural Homelessness

While the majority of individuals experiencing homelessness live in urban areas, estimates of rural homelessness range from 7 to 28 percent (the latter estimate includes suburban areas).¹¹³ Serving rural individuals experiencing homelessness presents additional barriers, including limited or non-existent public transportation systems and significant provider and housing shortages. Still, permanent supportive housing can generate savings even in rural areas. Data from a grant-funded initiative in **Maine** that provided permanent supportive housing to individuals and families experiencing homelessness in both rural and urban areas found second-year reductions in health care spending for rural participants.¹¹⁴

When comparing six-month periods before and after housing for rural residents, Maine reported:

- A 54 percent reduction in mental health service spending;
- A 23 percent decline in medical services;
- A 16 percent drop in ambulance services;
- And a 15 percent decrease in emergency department services.
- Notably, incarceration costs for these individuals fell 91 percent.¹¹⁵

Similar health-related savings were seen in the urban Greater Portland area, but higher housing costs offset the much of the net savings.

State Medicaid leadership may wish to review the extent to which telehealth or mobile health care programs are utilized in rural areas and determine the feasibility of financially incentivizing implementation or expansion of these models to expand access to care.

Telemedicine. CMS describes telemedicine as “a cost-effective alternative to... face-to-face [services],” and encourages states to “use the flexibility inherent in federal law to... incorporate telemedicine technology.”¹¹⁶ CMS specifically reimburses rural FQHCs and other safety-net providers as originating sites for telemedicine service in Medicare fee-for-service, which may help these providers build the infrastructure and capacity to also serve Medicaid populations.¹¹⁷ States are not required to submit a state plan amendment if telemedicine services are covered in the same way and amount as face-to-face services.¹¹⁸ Telemedicine programs may be particularly useful in increasing access to specialty behavioral health services in rural areas.¹¹⁹

Mobile Clinics. According to a 2012 report, more than 80 HCH programs across the country operated a mobile clinic in 2005-2006.” The most commonly reported operational barrier for these programs was “lack of financial capacity,” and while the payment landscape has likely changed over the past decade, Medicaid reimbursement was only available in 3 of the 33 programs¹²⁰ interviewed for the brief.¹²¹ Depending on the geography and scope of the program, urban-based mobile clinics may also serve remote or otherwise rural areas; 13 of the 33 programs operated in rural areas, including two that exclusively served rural populations.¹²² The transportation barriers that affect rural individuals may similarly affect mobile clinics. For example, one program serving both urban and rural areas had to discontinue rural services because they “required too much gas.”¹²³ This illustrates the importance and potential impact of community and cross-agency partnerships. For example, the **Ohio** Housing Finance Agency provided \$478,000 in grant funds to launch a mobile health clinic. While this program serves permanent supportive housing buildings in Cleveland, states could replicate the model in rural areas.¹²⁴

Medicaid Expansion

Finally, as Congress debates the future of the Affordable Care Act in summer 2017, it is worth reviewing the impact the law has had on individuals experiencing homelessness and safety net providers. In Medicaid expansion states, HCH programs saw significant improvements in client coverage, with insured rates increasing from 45 to 67 percent between 2012 and 2014. In non-expansion states, the percentage of HCH clients with insurance remained flat, increasing from 26 to 30 percent.¹²⁵ A recent study released by the National Healthcare for the Homeless Council had similar findings.¹²⁶ HCH programs fared better financially in expansion states. Based on 2013-2014 data, HCH program revenues grew 7 percent while costs rose 3 percent, while in non-expansion states program revenues grew by just 2 percent with costs increasing 9 percent.¹²⁷

A May 2017 report exploring the impact of **Ohio’s** Medicaid expansion found that homelessness fell 15.5 percent between 2013 and 2016. During the same period, the percentage of single adult Ohioans accessing homeless services who had Medicaid coverage increased from 30 percent to over 80 percent.^{128, 129} Although the statistical methods infer a correlation rather than causation, the authors noted that expansion increased access to behavioral health services that can help individuals maintain housing, and a telephonic survey of Medicaid enrollees conducted in 2016 found that roughly half of the respondents reported increased financial and housing stability.^{130, 131}

While some single adults experiencing homelessness may still qualify for Medicaid without expansion if they have a disability that qualifies for Supplemental Security Income (SSI) benefits, eligible individuals experiencing homelessness tend to face significant challenges in successfully applying for these benefits.^{132, 133, 134} The definitional issues addressed earlier also apply here. While substance use disorders qualify as a disability under federal housing rules,¹³⁵ a diagnosed substance use disorder does not qualify an individual for SSI benefits unless the substance use contributes to other specific conditions.¹³⁶ Furthermore, if a substance use disorder is found to contribute to a qualifying disability, federal regulations may require individuals to enter treatment, and they can lose benefits if they fail to comply,¹³⁷ which contradicts core tenets of Housing First. Expanded coverage policies that tie eligibility to income rather than requiring the presence of a disability may increase the likelihood that individuals experiencing homelessness will maintain health insurance.

Alternative Models of Expansion. Massachusetts began expanding Medicaid eligibility through the Section 1115 authority in 1997,¹³⁸ and at least eight states have leveraged 1115 demonstrations to expand Medicaid coverage since 2014.¹³⁹ In **Arkansas**, the first state to receive approval for a *private option* expansion model (so-called because of how the model uses Medicaid funds to

provide premium support for ACA marketplace plans), the uninsured rate among low-income adults fell from 42 percent in 2013 to 14 percent in 2015, with corresponding improvements in quality and utilization metrics.¹⁴⁰ Researchers found marked differences between Arkansas and neighboring Texas (which did not expand Medicaid) and insignificant differences between outcomes in Arkansas and Kentucky, a traditional Medicaid expansion state. These results led researchers to infer that the decision to expand Medicaid has a greater impact on outcomes than *how* the state decides to expand eligibility.

Although federal financial support for ACA-expansion populations may be rolled back or ultimately discontinued, states may wish to explore the feasibility of using the Section 1115 demonstration authority to continue existing programs or initiate new ones to expand eligibility beyond the federal floors to better meet the medical and psychosocial needs of individuals experiencing homelessness.

Conclusion

Health and housing are incontrovertibly linked. State Medicaid agencies have made significant investments by leveraging a wide range of federal authorities and delivery systems to improve coverage for supportive housing services. While the availability of affordable housing is limited, particularly for the lowest-income individuals and families, state Medicaid agencies have a tremendous opportunity to increase the effectiveness and efficiency of permanent supportive housing programs in urban and rural areas by partnering with—and fostering relationships across—health centers, community-based supportive housing providers, and key stakeholders in the housing sector. The growth of managed care and accountable care models provide unique opportunities for Medicaid leadership to incentivize—or require—a focus on improving care for individuals experiencing homelessness.

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Appendix A: Background

Homelessness in the United States

According to the U.S. Department of Housing and Urban Development (HUD), an estimated 549,928 people experienced homelessness in the United States on a single night in January 2016.¹ Approximately 14 percent of those experiencing homelessness (77,486) were individuals experiencing chronic homelessness, differentiated by the presence of a disability and having been either continuously homeless for one year or more or having experienced at least a total of 12 months of homelessness across four or more episodes in a three-year period.² An additional 8,646 people in families with children experienced chronic homelessness. While approximately two-thirds of all persons experiencing homelessness were sheltered, chronically homeless individuals were much more likely to be unsheltered (see **Table 1**).

Table 1 - January 2016 Point-in-Time Estimates of Homelessness

	Total	Sheltered	Unsheltered
All Homeless Individuals	355,212	198,008 (56%)	157,204 (44%)
<i>Chronically Homeless Individuals</i>	77,486	24,596 (32%)	52,890 (68%)
All Homeless People in Families with Children	194,716	175,563 (90%)	19,153 (10%)
<i>Chronically Homeless People in Families with Children</i>	8,646	5,512 (64%)	3,134 (36%)
Totals	549,928	373,571 (68%)	176,357 (32%)

Source: <https://www.hudexchange.info/resources/documents/2016-AHAR-Part-1.pdf>

Health and Housing

As one of the fundamental social determinants of health, the relationship between health and housing is well established. Homelessness can be both a driver and an outcome of poor health, and poor health may likewise increase the risk that an individual experiences homelessness. The literature shows that homeless populations are disproportionately impacted by chronic medical and behavioral health conditions,^{3, 4} and most have at least one unmet health care need.⁵

A 2005 literature review noted that age-adjusted mortality rates for homeless individuals are three- to four-times higher than the general population's, and the average life expectancy for homeless individuals is roughly half that of the national average (i.e., 42-52 years compared to approximately 80).⁶ While much of this difference can be attributed to underlying medical and behavioral health conditions, one international study found that homelessness was an independent risk factor for mortality. The study also found that homelessness increases the risk of dying from specific health-related causes, particularly for individuals with circulatory, respiratory, and drug-related conditions.⁷

In addition to poor health, research shows that individuals experiencing homelessness face significant barriers in accessing care, resulting in increased hospital emergency department and inpatient utilization.^{8, 9, 10} Homeless individuals often lack health insurance, and many who are eligible for Medicaid are not enrolled—even in states that expanded Medicaid eligibility.¹¹

Recent data suggests that housing may be the most influential factor in reducing hospital utilization. Data from a May 2017 study found that receiving housing services had a greater effect on emergency department utilization than either access to other services or health status.¹²

Medicaid's Role

Beyond covering the necessary medical and behavioral health services, state Medicaid programs can also be important partners in helping homeless individuals and families secure and maintain safe and affordable housing. While Medicaid funds cannot be used to pay for non-institutional room and board costs,¹³ state Medicaid programs can use a variety of authorities to cover housing-related activities and wrap-around services. In June 2015, the Centers for Medicare & Medicaid Services (CMS) released an informational bulletin that clearly articulated these opportunities for state Medicaid programs (see **Table 2**). The Office of the Assistant Secretary for Planning and Evaluation (ASPE) has developed a [comprehensive primer](#) for state Medicaid directors and senior staff detailing how state Medicaid programs can improve care for individuals experiencing chronic homelessness.¹⁴

Table 2 - Medicaid Authorities and Demonstration Programs That States Can Use to Cover Housing-Related Activities and Services as Identified by the Centers for Medicare & Medicaid Services

Authority	Housing-Related Activities and Services
1915(c) Home & Community-Based Services (HCBS) Waivers	<ul style="list-style-type: none"> • Case management activities related to transition and tenancy-sustaining services, including assessing housing needs and assisting in securing housing. • Necessary environmental accessibility-related modifications • Community transition services necessary to establishing a basic household, including security deposits, one-time set-up fees for utilities, essential household furnishings, moving expenses, and services necessary for health and safety (e.g., pest eradication, one-time cleaning prior to occupancy) <ul style="list-style-type: none"> • Community transition services must be reasonable and necessary, and are only allowable when an individual cannot meet the expense and there is no other source for the service). • Community transition services do NOT include monthly rental or mortgage expenses, food, regular utility charges, and/or recreational household appliances.
1915(i) HCBS State Plan Optional Benefit	<ul style="list-style-type: none"> • Housing-related services and activities allowable under a 1915(c) waiver (see above). <ul style="list-style-type: none"> • Unlike the 1915(c) waiver, individuals receiving services through the 1915(i) state plan option are not required to meet an institutional level of care requirement, however, “[s]tates must demonstrate that the institutional level of care criteria they apply [for 1915(c) waivers] are more stringent than the needs-based criteria established for 1915(i) State plan HCBS.”¹ • States are NOT allowed to waive state-wideness requirements or limit the number of individuals served.
1915(k) Community First Choice State Plan Optional Benefit	<ul style="list-style-type: none"> • Person-centered home and community-based attendant services and supports • Reimbursement for permissible services and supports linked to individuals’ assessed need in their person-centered plans, which includes: <ul style="list-style-type: none"> • Transition costs for individuals transitioning from an institution to the community, including one-time expenses required for the transition (including security deposits and first month’s rent) and purchase costs of bedding and basic kitchen supplies. • Expenditures that increase an individuals’ independence
1915(b) Managed Care Waivers	<ul style="list-style-type: none"> • Services otherwise coverable under a state plan or waiver delivered through a managed care delivery system • Savings may be used to cover additional services under 1915(b)(3) authority
1905(a) State Plan Services	<ul style="list-style-type: none"> • Targeted case management (may include linking individuals to housing resources and assisting in finding or maintaining housing)
Section 1115 Research and Demonstration Programs	<ul style="list-style-type: none"> • Community-based services • Assisting individuals in finding housing and other administrative supports (e.g., completing forms for housing subsidies, accessing community resources to assist with rent).
Money Follows the Person Rebalancing Demonstration²	<ul style="list-style-type: none"> • State-level housing collaborative activities to create, identify, and secure affordable, accessible rental housing resources meeting program requirements • Housing-related transition services to assist individuals in locating, applying for, and moving into housing. • Housing stabilization and tenancy support services

Source: Table adapted from: <https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-06-26-2015.pdf>.

¹ <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD040408.pdf>;

² Federal authorization for Money Follows the Person expired Sept. 30, 2016, however, states may carry over unused funds from grants awarded in FY 2016 through FY 2020.

The Safety Net's Role

Individuals experiencing homelessness—particularly those with unmet behavioral health needs—often lack a primary care provider or other usual source of care, which can result in overutilization of hospital emergency departments for non-emergency services and preventable admissions for ambulatory care sensitive conditions.^{15, 16} Health centers, as defined in Section 330 of the Public Health Service Act,¹⁷ serve medically underserved populations and are critical partners in establishing a usual source of care for homeless individuals and families. In particular, Health Care for the Homeless (HCH) programs, funded through Section 330(h) of the Public Health Service Act,¹⁸ are specifically charged with providing comprehensive primary health and substance abuse services to homeless individuals and families (including those staying in temporary supervised facilities and transitional housing residents).¹⁹ These HCH programs may continue to provide services for up to 12 months after an individual becomes a resident in permanent housing.²⁰ Although mental health services are not statutorily required, many health centers and HCH programs either directly provide or subcontract for specialty mental health services.²¹ Through a mix of on-site, satellite, and mobile/in-home delivery models, health centers and HCH programs across the country are also key providers (or partners) for wraparound supportive housing services.²²

Appendix Endnotes

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