NATIONAL ACADEMY
for STATE HEALTH POLICY

Chronic Homelessness and High Users of Health Services:
Report from a Meeting to Explore a Strategy for Reducing Medicaid Spending While Improving Care

Neva Kaye
Cheryl Harris Sharman
Jill Rosenthal

January 2008

COMMON GROUND

Chronic Homelessness and High Users Of Health Services:

Report from a Meeting to Explore a Strategy for Reducing Medicaid Spending While Improving Care

---

Neva Kaye
Cheryl Harris Sharman
Jill Rosenthal

Chronic Homelessness and High Users of Health Services:
Report from a Meeting to Explore a Strategy for Reducing Medicaid Spending While Improving Care

Publication No.: 2008-201
Available on the Web at: www.nashp.org/Files/chronic_homelessness.pdf

About the National Academy for State Health Policy

The National Academy for State Health Policy is an independent academy of state health policy makers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice.

NASHP provides a forum for constructive, nonpartisan work across branches and agencies of state government on critical health issues facing states. We are a non-profit, non-partisan, organization dedicated to helping states achieve excellence in health policy and practice.

To accomplish our mission we:

- Convene state leaders to solve problems and share solutions.
- Conduct policy analyses and research.
- Disseminate information on state policies and programs.
- Provide technical assistance to states.

The responsibility for health care and health care policy does not reside in a single state agency or department. NASHP provides a unique forum for productive interchange across all lines of authority, including executive offices and the legislative branch.

We work across a broad range of health policy topics including:

- Medicaid.
- Long-term and chronic care.
- Public health issues, including obesity.
- Quality and patient safety.
- Insurance coverage and cost containment.
- The State Children's Health Insurance Program.

NASHP's strengths and capabilities include:

- Active participation by a large number of volunteer state officials.
- Developing consensus reports through active involvement in discussions among people with disparate political views.
- Holding large and small conferences and meetings with substantial user input in defining the agenda.
- Distilling the literature in language useable and useful for practitioners.
- Identifying and describing emerging and promising practices.
- Developing leadership capacity within states by enabling communication within and across states.

For more information about NASHP and its work, visit www.nashp.org

Portland, Maine Office:
50 Monument Square, Suite 502
Portland, Maine 04101
Phone: (207) 874-6524
Fax: (207) 874-6527

Washington, D.C. Office:
1233 20th St., N.W., Suite 303
Washington, D.C. 20036
Phone: (202) 903-0101
Fax: (202) 903-2790

TABLE OF CONTENTS

ACKNOWLEDGEMENTS

The authors wish to thank the Rockefeller Foundation for providing financial support and Common Ground for conceptualizing and hosting the meeting on which this report is based. We thank the presenters and meeting participants for sharing their experiences and perspectives with us and with each other. A list of participants is included in Appendix A.

EXECUTIVE SUMMARY

There is evidence that homeless people, especially the chronically homeless, incur high health care costs, much of which may be paid for with Medicaid funds. There is also evidence that health care costs are reduced when homeless people with intensive medical needs enter supportive housing, which combines affordable, stable housing with care workers who assist residents in managing health, mental health, substance abuse, and employment issues.

This evidence, along with evidence that the proportion of homeless people who are chronically homeless is small, provides a potential opportunity for states to reduce Medicaid costs by increasing their investment in housing. In April 2007, a small group of homeless and housing advocates, state health care leaders, and managed care providers met to explore this opportunity.

Meeting participants examined the experience of three supportive housing programs that have demonstrated a positive relationship between providing supportive housing to the chronically homeless, changes in health care utilization, and reductions in medical costs. Participants also reviewed Medicaid regulations governing what people and what services states may choose to cover through Medicaid, including the federal Medicaid prohibition against paying for 'room and board.'

Using the information presented at the meeting, as well as their own knowledge and experience, participants identified the following opportunities for and barriers to state action regarding Medicaid's potential to support housing for the chronically homeless ***and*** the potential of supportive housing to reduce Medicaid costs.

- States could create targeted capitated managed care programs to serve Medicaid beneficiaries who are chronically homeless and who have high Medicaid costs. Participants were particularly interested in a capitated program's ability to use savings to cover housing and combine payments from multiple funders to provide an effective and coordinated package of housing and supportive services.

- States could review their current Medicaid policies to identify potential modifications to qualify some of the services provided by supportive housing in Medicaid (e.g., personal care). States could also establish targeted case management (TCM) services to serve homeless Medicaid beneficiaries, as Utah has done. Finally, supportive housing programs could explore whether some of the services they provide already qualify for Medicaid funding (e.g., some states cover services provided by Assertive Community Treatment (ACT) teams, which are fielded by some supportive housing programs).

- Several potential clarifications or changes to federal Medicaid law that would increase the utility of Medicaid to cover supportive housing services surfaced at the meeting, but not all meeting participants agreed that all changes were needed. The most requested clarification was regarding the conditions under which the case management services provided to Medicaid beneficiaries by supportive housing programs could qualify as TCM services.

- The federal government could allow a few state Medicaid agencies to pilot potential interventions for chronically homeless Medicaid beneficiaries who have high medical costs.

- Researchers could conduct studies to develop analysis and information for designing programs that take advantage of the links among homelessness, supportive housing, and high Medicaid costs.

□ □ □

INTRODUCTION

There is growing evidence that homeless people, especially the chronically homeless, incur high health care costs, much of which may be paid for with state funding, including Medicaid funding.[1] There is also evidence that health care costs are reduced when homeless people with intensive medical needs (including mental health and substance abuse needs) enter supportive housing, which combines affordable, stable housing with care workers who assist formerly homeless residents in managing health, mental health, substance abuse, and employment issues.

Medicaid, which pays for health care services delivered to poor and low-income Americans, is a major purchaser of health care services. In 2005, the program paid about $305 billion to provide health and long-term care services to Medicaid beneficiaries.[2] The percent of Medicaid spending that is due to providing services to homeless individuals is unclear. It is clear, however, that relatively few Medicaid beneficiaries account for a large share of Medicaid spending. For example, in 2001, 4% of Medicaid beneficiaries accounted for 48% of all expenditures.[3]

Case findings analysis can be used to identify chronically homeless individuals who are high-cost health care users. Researchers from the Wagner School of Public Service have developed an algorithm that analyzes Medicaid paid claims data to predict with great reliability which patients who are high health care users are at high risk for re-hospitalization. In one study the researchers used the algorithm to identify a sample of high cost patients predicted to be at high risk of re-hospitalization. These patients were interviewed, and half were determined to have been homeless at some point in the previous two years.[4]

This link between homelessness, supportive housing, and health care cost and utilization, along with the relatively small proportion of homeless people who are chronically homeless (about 10 percent) provides a potential opportunity for states to reduce Medicaid costs by increasing their investment in housing.[5] In April 2007, Common Ground convened a small invitational meeting of homeless and housing advocates and state health care leaders to explore this opportunity.[6] The National Academy for State Health Policy (NASHP) facilitated the meeting. (Please see Appendix A for a complete list of meeting participants.)

This paper presents a summary of the discussion at this meeting during which participants examined: the link between health care services/costs and chronic homelessness; existing models of supportive housing; the role Medicaid funding plays in paying for health care services provided to chronically homeless people; how states might reduce those costs by investing in supportive housing; and how states might make those investments.

□ □ □

LINKING CHRONIC HOMELESSNESS, SUPPORTIVE HOUSING, AND HEALTH CARE UTILIZATION AND COST

Experience and research have demonstrated that supportive housing is an effective, lower-cost intervention for homeless individuals with medical needs, including mental health and substance abuse. Supportive housing, usually operated by non-profit groups, combines affordable, stable housing with care workers who assist formerly homeless residents in managing health, mental health, substance abuse, and employment issues. Supportive housing takes a variety of forms, from special purpose buildings managed by non-profits, to individual apartments rented from private landlords where formerly homeless tenants with medical needs are regularly visited by care workers.

The per person costs of supportive housing, including rent subsidies and care management costs, vary with the type of living arrangement and intensity of the care support. The annual cost of the three programs discussed at the meeting ranged from $12,300 to $22,500 per person. Nationally, housing retention rates of 60 to 90 percent are typical in supportive housing.[7]

"There are sixty-five cost-benefit studies in cities with 10-year plans ongoing, with consistent findings: it's cost-beneficial."
~Policymaker

The impact of housing on highest cost health care system users has not been evaluated, but studies of the general homeless population demonstrate the high medical costs of homelessness and how health care cost and utilization are reduced once housing and care management services are in place. For example,[8]

- Boston, Massachusetts: 119 persons who experienced chronic homelessness for 5 years had more than 18,000 emergency room visits at an average cost of $1,000 per visit.[9]
- Asheville, North Carolina: Over a period of three years, 37 homeless men and women cost the city and county more than $800,000 each year, including 280 episodes of EMS services for $120,000 and $425,000 in hospitalization costs.[10]
- Atlanta, Georgia: A cost-benefit study followed 60 mentally ill individuals supported in housing through Forensic Assertive Community Treatment (FACT) teams. In one year, decreases in hospitalization, incarceration, and arrests accounted for more than $1 million in savings.[11]
- Denver, Colorado: Placing individuals in the Housing First program saved nearly $600,000 in emergency-related costs over a period of two years. This represents a 73 percent reduction in total emergency-related costs for the sample.[12]

Finally, a study by the Wagner School of Public Service indicates that homeless individuals are disproportionately represented among Medicaid beneficiaries with high medical costs. Researchers used an algorithm to identify 50 high cost Medicaid beneficiaries who were treated at Bellevue Hospital in New York within the past five years and who were at high risk for re-hospitalization. About 60 percent of these beneficiaries were homeless at the time of the interview and 50 percent had been homeless within the two years before the interview.[13] Researchers posit that establishing a multi-disciplinary team that will arrange and follow through

to ensure provision of post-discharge support to members of this predicted high-cost group will result in reduced medical costs – and that housing will be a critical element of the post-discharge support. The researchers and Common Ground are currently engaged in a pilot program to test this theory.[14]

Supportive Housing Programs have Demonstrated that They Reduce Health Care Utilization and Cost

The meeting included representatives of three organizations that operate supportive housing programs. These representatives described their models, their costs, and the changes each has produced in health care cost and utilization.

- The Direct Access to Housing (DAH) program offers supportive housing and health care services to homeless individuals in San Francisco. The DAH, directed by the city's Department of Public Health, focuses on high cost users of a range of publicly funded health services in San Francisco. DAH combines multiple local, state, and federal funding streams with tenant rents and clinical service reimbursements to provide these services to homeless individuals. Housing and services cost about $1,500 per person per month, of which residents pay an average of about $300 per month. Clinical services are provided both in residences and at a Federally Qualified Health Care Center (FQHC) dedicated to these formerly homeless individuals.[15] Almost 80 percent of the 900 monthly visits to the FQHC are by Medicaid beneficiaries.[16] After they moved into permanent supportive housing, program participants used emergency departments 58 percent less. During their first two years in housing, they had 57 percent fewer inpatient episodes than in the two previous years. The number of psychiatric inpatient hospitalizations did not change much, but the duration of stays decreased significantly.[17]

- Pathways to Housing (Pathways) seeks to care for the most vulnerable segment of New York City's mentally ill homeless population. Program participants with mental illness often have co-occurring substance abuse disorders and other diagnoses. Pathways offers apartments and clinical care via Assertive Community Treatment (ACT) teams. The annual cost of the apartment rental and ACT team is about $22,500 per person. Program participants pay about 30 percent of the housing costs and Medicaid pays for the ACT teams. No one is required to seek psychiatric or substance abuse treatment as a condition of their housing. Several studies have evaluated the efficacy of the Pathways to Housing model. Results vary slightly for different studies, but overall confirm that between 78 to 88 percent of those in Pathways apartments remain housed. One study looked at 57 frequent users of inpatient psychiatric hospital services and found that after being referred to Pathways their average number of days in the hospital decreased from 327 days to 27 days.[18]

- The Chicago Housing for Health Partnership (CHHP) is a program that provides housing and case management to homeless people with HIV/AIDS. The CHHP followed 436 people who qualified for the program – 220 people were randomly assigned to a control group that received the 'usual care' and 216 people received intervention services: expedited hospital discharge through placement in interim housing, access to long-term scattered-site housing, and specialized case management services. The case management services were delivered

through a team that included two case managers at the hospital, three case managers based in the interim housing, ten case managers assigned to the scattered-site housing, and one coordinator for the entire team. The scattered-site housing with services costs $34 per day (or $1,025 per month), including rent and case management services. CHHP found that:

- While the two groups used a total of 10,559 nursing homes days during the study period, the group receiving the intervention services used only 25 percent of those days. This difference indicates significant cost savings potential, as nursing home services in Chicago can cost as much as $132 per day, or $3,960 per month.
- Members of the control group made an average of 4.9 visits per person to the emergency room while the intervention group averaged 1.7 visits per person.
- Hospitalizations, which cost about $2,000 per day, also declined substantially among the intervention group.[19]

□ □ □

MEDICAID AND THE SERVICES DELIVERED TO HOMELESS INDIVIDUALS

> **"…we must make certain that Medicaid is appropriately accessible to address the particular medical and health needs of the chronically homeless so that they are able to get and keep housing."**
> ***~Policymaker***

Medicaid is a major purchaser of health care services.[20] States administer Medicaid within guidelines set by the federal government. The federal government reimburses states for a portion of the cost to administer the program and the cost of qualified services delivered to qualified people, when medically necessary. Within the federal guidelines each state determines what it will consider to be a 'qualified service' and a 'qualified person.' In other words, each state decides who the program will cover, what services the program will cover, how (and how much) the program will pay for services, how services will be delivered, and how to ensure/improve program performance. Further, the state's definition of medical necessity determines the circumstances under which a covered service provided to an individual covered by the program qualifies for payment. The federal guidelines limiting who and what services states may choose to cover are particularly critical to understanding Medicaid's role in delivering services to homeless individuals.

Who States May Cover

Current federal Medicaid law requires states to cover members of certain groups if they have incomes below a specified limit, which varies based on the category to which the individual belongs. The primary groups states must cover include:

- ***Families***: Medicaid programs must cover members of families who would have qualified for cash assistance under the state's AFDC (Aid to Families with Dependent Children) program under the rules in effect in July 1996. The mandatory minimum income limit for this group varies by state and is often far below the federal poverty level (FPL).
- ***Pregnant women:*** Pregnant women from families earning no more than 133 percent of the FPL. Some states are required to also cover pregnant women at higher levels of income, if that level was in effect in December 1989.
- ***Children***: Medicaid programs must cover both children who belong to families with incomes below a specified limit that varies by the child's age (e.g., children under age 6 from families with incomes of no more than 133 percent of the FPL) and children who are served by certain other programs (e.g., children receiving foster care assistance under Title IV-E).
- ***Elderly***: Most Medicaid programs must cover people who are over age 64 and who qualify for Supplemental Security Income (SSI) payments; some are allowed to use more restrictive criteria if the criteria were in place in January 1972.
- ***People with disability:*** Most Medicaid programs must cover people with disabilities who qualify for SSI payments; some are allowed to use more restrictive criteria if the criteria were in place in January 1972.

The law also permits states to choose to cover members of these groups with incomes above these federal limits. It does not permit states to cover people who do not belong to one of these groups without an approved '1115 waiver' from the federal government.[21] In other words, unless

they have a waiver, state Medicaid programs may not cover non-disabled, working age, childless adults regardless of their income. Two of the states represented at the meeting (New York and Utah) have 1115 waivers that allow them to cover non-disabled, working age, childless adults. Additionally, Minnesota and Rhode Island have 1115 waivers that allow them to cover parents at higher income levels than otherwise allowed under Medicaid.[22]

Services States May Cover

Current federal Medicaid law requires states to cover certain services (e.g., physician and hospital services), allows them to choose to cover certain services (e.g., mental health and pharmacy services), and forbids them from covering other services (e.g., 'room and board'). The federal government may, at a state's request, waive many of these federal requirements – it may not, however, approve a waiver allowing a state to use federal Medicaid funding to pay for room and board.[23] Thus, federal Medicaid funding currently cannot be used to pay for housing for homeless individuals. It can be used to pay for the following services, among others:

- Medical services, including physician, inpatient, outpatient, dental, and prescription drug services.
- Mental health and substance abuse services, including outpatient, clinic, rehabilitative, and some inpatient services.
- Long-term care services and supports, including nursing home services, personal care for people who meet the criteria for admission to a nursing home, and many of the services needed to maintain, in the community, people who qualify for care in an institution.
- Care coordination services, including disease management and targeted case management (TCM)[24] services.
- Supportive services, including transportation to obtain medically necessary services.

Two other issues are relevant to this discussion of covered services: capitated services and benchmark plans.

- States may choose to deliver some or all covered services through a 'capitated' managed care system. Under capitation the state pays a set amount per member per month (capitation payment) to a contracted entity that, in return, agrees to manage and deliver a defined package of benefits to a defined group of beneficiaries. States may choose to contract for delivery of a comprehensive set of benefits or a limited set of benefits (e.g., mental health services). Under a capitated arrangement contractors may choose to cover services that are not otherwise covered by Medicaid from any savings they produce by managing the contracted benefits.[25] Also, states may, with an approved waiver, share the cost savings produced by more cost-effective use of medical care with beneficiaries by providing additional services.[26] The capitation rate must be actuarially sound and no higher than the fee-for-service cost of delivering the contracted services.[27]

- The Deficit Reduction Act of 2005 (DRA) allows states to choose to establish benchmark plans. A benchmark plan is one that meets one of three benchmarks established in the DRA (e.g., the benefit package offered to state employees). Further, states may require some program participants to enroll in a benchmark plan (e.g., adults and children who qualify for

Medicaid family coverage) and allow other program participants to choose to enroll (e.g., people who qualify for Medicaid due to disability). States may choose to limit the benefits provided to adults enrolled in a benchmark plan to only those benefits covered by the plan, but must continue to provide children enrolled in a benchmark plan with the full Medicaid package.[28]

Medicaid Waivers

States may obtain three different types of waivers from the federal government. Under waivers states may implement policies that are otherwise not allowed under federal Medicaid law.

- Under ***§1115 waiver*** authority, the Secretary of the Department of Health and Human Services (the Secretary) may waive most federal requirements, including those related to who and what services a state may choose to cover. For example, a state could cover non-disabled, working age, childless adults under an 1115 waiver. The Secretary may not, however, allow a state to cover room and board. These waivers must be 'budget neutral' (i.e., result in no increased cost to the federal government), periodically renewed (usually every five years), include an evaluation, and may be subject to additional terms and conditions imposed by the federal government.

- Under ***§1915(b) waiver*** authority, the Secretary may allow a state to limit a beneficiary's choice of provider. For example, a state could require a beneficiary to enroll into a managed care organization under a 1915 waiver. A state may not spend more under a 1915 waiver than it would without the waiver. Also, these waivers must be renewed every two years.

- Under ***§1915(c) waiver*** authority, the Secretary may allow a state to cover the services and supports needed to maintain in the community a beneficiary who qualifies for care in an institution (e.g., hospital or Intermediate Care Facility). 1915(c) waivers are often referred to as Home and Community-Based Services (HCBS) waivers. States may limit participation in the waiver to subcategories of beneficiaries (e.g., those who qualify for nursing home care) and they may limit the absolute number of people served by the waiver (waiver participants). States may offer services to waiver participants that it does not otherwise cover under Medicaid. A state may not spend more under an HCBS waiver than it would without the waiver and the waivers must be periodically renewed – the initial waiver expires after three years and subsequent waivers expire after five years. (The DRA created an option for states to cover home and community-based services without a waiver.)[29]

□ □ □

MEDICAID'S POTENTIAL TO SUPPORT HOUSING FOR THE CHRONICALLY HOMELESS

The discussion among policy makers, representatives of supportive housing programs, and representatives of capitated Medicaid managed care contractors identified several ways that states could use Medicaid funding to help address long-term homelessness under current federal Medicaid law. Of course, as previously discussed, states may expand their Medicaid programs to cover groups that are likely to include long-term homeless people. In addition, states have options to restructure their benefit packages and delivery systems to facilitate the provision of supportive housing to high-cost Medicaid beneficiaries who are chronically homeless. States may wish to consider these options due to the evidence linking chronic homelessness, supportive housing, and health care cost and utilization. The discussion also identified some clarifications and/or changes to current Medicaid law and areas for further research that would increase the usefulness of Medicaid for covering supportive housing and thus provide potential cost-savings for states and the federal government.

Using Capitation

As previously discussed, Medicaid agencies may choose to deliver some or all covered benefits to some or all Medicaid beneficiaries through a capitated managed care system. The contractors who deliver care under such a system usually accept financial risk for providing those services – and may reinvest any savings they achieve into additional services, such as housing. Meeting participants were also interested in the potential of capitation for improving coordination of funding streams and establishing performance-based contracting that includes 'housing first' as a performance standard.[30]

"There are issues involved with capitation but it can provide a good avenue for addressing the needs of specific populations."
~Managed Care Provider

There is precedent in Medicaid for targeting capitated programs to a subgroup of Medicaid beneficiaries who meet certain criteria. For example, a representative of New York's Independence Care System participated in the meeting. Independence Care System is a nonprofit organization that facilitates independent living for people with physical disabilities. It operates a Medicaid managed long-term care plan for 1,100 people in New York City. Other states have also established managed care programs that include elements similar to those of interest to meeting participants.

- Since the mid-1990s, Massachusetts has operated a program that serves people with HIV. The capitation payment is set based on the cost of serving members of this group in Medicaid's fee-for-service program, the package of covered benefits is designed to meet the needs of this population, and contractors must meet criteria demonstrating their ability to serve this population.[31]

- Since the 1990s, Wisconsin has operated a program that serves children with severe emotional disturbances who are at-risk for entry into the juvenile justice system. The

managed care contractor contracts with (and receives payments from) the state Medicaid agency and local government to serve program participants.[32]

- New Mexico recently implemented a program that uses capitation to streamline delivery of behavioral health services across state agencies. Previously, 15 different agencies were contracting out services for mental health or substance abuse treatment, many times from the same providers and for the same target populations, but often paying different rates and having different expectations. All 15 agencies worked together to develop this new program under which they purchase mental health services from a single contractor who is responsible for managing all services and meeting performance expectations set by the group. [33]

States considering establishing a capitated program targeted to chronically homeless beneficiaries or chronically homeless beneficiaries with high medical costs will need to consider issues related to:

- criteria for participation of both beneficiaries and contractors,
- how to develop an actuarially sound capitation rate that is based on the cost of serving program participants in an 'unmanaged' system,
- which services to include in the contract,
- what performance expectations to establish, and
- how to ensure that the contractor's performance meets those expectations.

States considering establishing a capitated program may wish to refer to *Optional Purchasing Specifications: Medicaid Managed Care for Individuals Who Are Homeless*, developed by the George Washington University Center for Health Services Research and Policy.[34]

In addition, states will need to consider how much flexibility they have in the design of Medicaid managed care programs. New York, for example, reports that in negotiations to implement its 1115 waiver it committed to excluding many services from managed care, including prescription drugs, detoxification treatment, and many mental health services. It may not be possible under the existing waiver to generate enough savings from the services that the state can include in capitation to pay for the services that some program participants envision being provided by a managed care program for chronically homeless individuals (e.g., housing).

Defining Medicaid Qualified Beneficiaries and Qualified Services

"We could increase our capacity if Medicaid could pay for services."
~Supportive Housing Program Administrator

Supportive housing provides a range of services to homeless individuals, including case management and sometimes medical, mental health, or substance abuse services. Under current federal law Medicaid can serve as a funding source for these services to the extent that both the people served and the services provided qualify for Medicaid payment. States can define covered Medicaid services to accommodate these supportive housing services.

Two of the states represented at the meeting have expanded their Medicaid programs to serve some poor or low-income non-disabled, working age, childless adults (New York and Utah). Among other things, these eligibility expansions enable more homeless individuals to qualify for Medicaid. The expansions also may speed and simplify program entry by, for example, eliminating the need for many adults to demonstrate that they are disabled before joining the program.

Among the states represented at the meeting, Utah offers the most pertinent example of a Medicaid covered service that could include services provided by supportive housing programs. The state established a Targeted Case Management (TCM) service for the homeless in 1992. TCM services are provided by staff from The Road Home, which is an agency that provides support and shelter for overcoming homelessness. States considering establishing a TCM program should review new provisions established by the DRA that prohibit states from using federal Medicaid funding to pay for services for which another state or federally funded program is responsible.

States wishing to fund services provided through supportive housing could examine their criteria for qualified providers and for other covered services to identify ways to modify definitions, within sound medical practice and federal Medicaid guidelines, to enable supportive housing providers and services to qualify for coverage. For example, states can cover personal assistance services provided by supportive housing programs (and other providers). Improved dialogue between supportive housing providers and state Medicaid programs could result in recognition of these providers as Medicaid qualified providers in order to be Medicaid reimbursable.

Finally, it is possible that supportive housing programs are already providing services that qualify (or could qualify) for Medicaid funding but are not billing for those services. For example,

- As of July 2003, 45 states covered TCM services for some or all people with severe mental health conditions.[35] It is possible that some of the case management services provided by supportive housing programs could qualify for Medicaid payment as TCM services.
- States are required to cover FQHC services. The Direct Access to Housing program established an FQHC to deliver medical services to program participants. Other programs could potentially do the same.
- As of July 2003, 43 states covered mental health crisis services.[36] Some of these states specified that they covered services delivered by Assertive Community Treatment (ACT) teams, which are fielded by some supportive housing programs (among other providers).

Clarifying and Changing Federal Law

One strategy to reduce overall health care spending and improve the health of homeless individuals is to improve enrollment strategies for homeless individuals who are already eligible for Medicaid services but who are not enrolled. Many mainstream resources are underused by homeless individuals due to a variety of barriers. These barriers have been the target of federal government agencies and the Interagency Council on Homelessness through efforts to increase the use of mainstream resources by the chronically homeless, including Medicaid;

increasing the number of Federally Qualified Health Centers; and the federal interagency Policy Academies on Chronic Homelessness.[37]

Although critical, these steps have not addressed some of the issues that surfaced at the meeting. Finding secure housing is the first and most pressing of needs for many individuals, and the increased costs of health care and criminal justice, as well as lost potential due to homelessness could be addressed through Housing First programs.[38]

Meeting participants discussed several areas where clarification or changes to federal Medicaid policies would enable states to more easily invest in housing to reduce Medicaid costs. Discussion of clarifications and changes included the following:

- Clarification that the case management services provided by supportive housing programs to homeless individuals can qualify for reimbursement as a TCM service – and delineation of the requirements the beneficiaries and services have to meet in order to qualify for payment.
- Confirmation that states can establish managed care programs specifically designed to serve the chronically homeless.
- Creation of a new state option to enable state Medicaid agencies to cover supportive services provided to homeless individuals, possibly including payment of 'room and board.'
- Clarification of the extent to which supportive housing programs and providers can share health care information.

It should be noted that not all meeting participants agreed with all of these suggestions; these are simply a list of the suggestions that arose at the meeting. In particular, the creation of a new state option to cover 'room and board' engendered a lot of discussion both during and after the meeting. This discussion resulted in the suggestion for pilot programs discussed in the next section.

Enabling Medicaid Agencies to Pilot Potential Interventions for Chronically Homeless Medicaid Beneficiaries with High Medical Costs

States have found that demonstration, or pilot, projects can effectively test new ideas and ground policy changes in real life experience. The three supportive housing programs described earlier in this report (Direct Access to Housing, Pathways to Housing, and the Chicago Housing for Health Partnership) all provided permanent housing and services for chronically homeless individuals. All three have shown that this approach reduces health care costs. However, due to the federal Medicaid prohibition on using federal Medicaid funding to cover 'room and board' as a Medicaid service these programs have not been able to fully demonstrate (or quantify) the utility of their approach for producing cost savings in Medicaid. State health policy makers and supportive housing program administrators expressed an interest in testing the coverage of 'room and board' as a Medicaid cost savings strategy mixed with caution about the

"…there is much more work to be done in this area...this is only the beginning of the dialogue."
~Homeless program manager

extent of savings such coverage might provide and how becoming a 'Medicaid service' might change supportive housing.

After much discussion, meeting participants concluded it would be beneficial for the federal government allow a few states to implement room and board coverage under Medicaid for beneficiaries who are both high cost and chronically homeless. This would enable those states and supportive housing programs to develop and test models, probably under a federal waiver, for covering 'room and board' as a Medicaid service, to quantify the potential savings under the various models, and to examine the effect on supportive housing programs of covering housing. Meeting participants believed this information would be needed to make informed policy decisions. Establishing such a program would require Congressional action, as the 'room and board' prohibition may not be waived under existing Medicaid waiver authority.

Research to Better Understand the Links among Homelessness, Supportive Housing, and High Medicaid Costs

Although the evidence presented at the meeting for the links among homelessness, supportive housing, and high medical costs was compelling, participants believed that more research on a few issues would strengthen the case for new policy initiatives. Results from the previously described pilots would answer these questions, as could other research. Answering the following questions would be particularly beneficial:

- What proportion of Medicaid beneficiaries with high costs are homeless? What proportion is chronically homeless?
- What is known about Medicaid coverage and persons who are homeless through enrollment data?
- Is chronic homelessness a predictor of high Medicaid costs? For what types of covered services (e.g., physician services, mental health treatment services, emergency services)?
- How does providing supportive housing to high-cost Medicaid beneficiaries who are chronically homeless change utilization of covered services? What are the costs? How do these changes vary among types of covered services?

□ □ □

SUMMARY

There is evidence that homeless people, especially the chronically homeless, incur high health care costs, much of which may be paid for by Medicaid. There is also evidence that health care costs are reduced when homeless people with intensive medical needs enter supportive housing. Further, there is also evidence that (1) a small proportion of the homeless are chronically homeless, and (2) a small proportion of Medicaid beneficiaries cost the most to serve. Finally, there is some evidence that the members of these two groups overlap so that providing supportive housing to individuals who belong to ***both*** groups could reduce Medicaid costs. A group of homeless and housing advocates, state health care leaders, and managed care contractors met to explore this opportunity. They identified the following opportunities and barriers regarding Medicaid's potential to support housing for the chronically homeless ***and*** the potential of supportive housing to reduce Medicaid costs.

- States could create targeted capitated managed care programs to serve Medicaid beneficiaries with high Medicaid costs who are chronically homeless. Participants were particularly interested in a capitated program's ability to use savings to cover housing and combine payments from multiple funders to provide an effective and coordinated package of housing and supportive services.

- States could review their current Medicaid policies to identify potential modifications to qualify some of the services provided by supportive housing in Medicaid.

- Several potential clarifications or changes to federal Medicaid law that would increase the utility of Medicaid to cover supportive housing services surfaced at the meeting, but not all meeting participants agreed on all changes.

- The federal government could allow a few state Medicaid agencies to pilot potential interventions for chronically homeless Medicaid beneficiaries with high medical costs.

- Researchers could conduct studies to provide information to help design programs that explore the links between homelessness and high Medicaid utilization, and the impact of supportive housing in reducing Medicaid expenditures for this targeted group.

These opportunities may work toward fulfilling the vision of one prominent provider of medical services for homeless individuals: "In addition to prescribing an antibiotic or insulin or a blood pressure medication, I dream of writing a prescription for an apartment, a studio, an SRO [single room occupancy], or any safe housing program, good for 1 month, with 12 month refills."[39]

□ □ □

Notes

[1] A person who is "chronically homeless" is an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or has had at least four episodes of homelessness in the past three years. In order to be considered chronically homeless, a person must have been sleeping in a place not meant for human habitation (e.g., living on the streets) and/or in an emergency homeless shelter. A disabling condition is defined as "a diagnosable substance use disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions." 42 CFR 435.908

[2] John Holahan, Mindy Cohen, and David Rousseau, *Why Did Medicaid Spending Decline in 2006? A Detailed Look at Program Spending and Enrollment, 2000-2006*. October 2007; The Kaiser Family Foundation; retrieved 21 November 2007; http://www.kff.org/medicaid/7697.cfm.

[3] Kaiser Commission on Medicaid and the Uninsured, "Medicaid at a Glance, fact sheet", March 2007; The Kaiser Family Foundation; retrieved 21 November 2007; http://www.kff.org/medicaid/upload/7235-02.pdf.

[4] John Billing and Maria Raven, Center for Health and Public Service Research. Robert F. Wagner Graduate School of Public Service, New York University, *Improving Health and Health/Social Care Services For High Cost Medicaid Patients,* presentation at Common Ground-NASHP meeting "High Users of Publicly-Funded Health Services: A Strategy for Reducing Spending While Improving Care," held April 24-25, 2007 in New York City.

[5] Dennis P. Culhane, Stephen Metraux, and S.M Wachter, "Homelessness and the Provision of Public Shelter in New York City." In M. Schill (ed.). *Housing in New York City,* (Albany, NY: SUNY Press, 1999).

[6] Common Ground is an organization dedicated to solving homelessness through innovative programs that transform people, buildings, and communities (www.commonground.org).

[7] Sources:
(1) Clare Nolan et al., *The Family Permanent Supportive Housing Initiative: Family History and Experiences in Supportive Housing* (Washington, DC: The Urban Institute and Harder+Company Community Research, August 2005).
(2) Dennis P. Culhane, Stephen Metraux, and Trevor Hadley, "The Impact of Supportive Housing for Homeless People with Severe Mental Illness on the Utilization of the Public Health, Corrections, and Emergency Shelter Systems: The New York-New York Initiative," (Philadelphia, PA: Center for Mental Health Policy and Services Research University of Pennsylvania May 2001).

[8] All examples in this list are originally from: Philip Mangano, *High Users of Publicly-Funded Health Services: A Strategy for Reducing Spending While Improving Care*, (United States Interagency Council on Homelessness), presentation at Common Ground-NASHP meeting on "High Users of Publicly-Funded Health Services: A Strategy for Reducing Spending While Improving Care," held April 24-25, 2007 in New York City.

[9] Ongoing research by Boston Health Care for the Homeless cited in Philip Mangano, *High Users of Publicly-Funded Health Services: A Strategy for Reducing Spending While Improving Care*, (United States Interagency Council on Homelessness), presentation at Common Ground-NASHP meeting on "High Users of Publicly-Funded Health Services: A Strategy for Reducing Spending While Improving Care," held April 24-25, 2007 in New York City.

[10] Sources:
Article: "Asheville city council approves 10-year homeless plan," (Asheville, NC: Asheville Tribune) http://www.ashevilletribune.com/archives/gaymiages.html;
Charlotte Chaplan, Staff Report: 10-Year Plan to End Homelessness, (Asheville, NC and Buncombe County, NC January 11, 2005); retrieved 16 November 2007; http://www.ich.gov/slocal/plans/asheville.pdf.

[11] Charidy Vinson, "Study shows treatment programs for homeless can save public millions of dollars" Press release: United Way of Metropolitan Atlanta, August 7, 2006, retrieved 16 November 2007; http://www.unitedwayatlanta.org/docs/news/2006/UWMA_release-2006-08-07.pdf.

[12] Jennifer Perlman and John Parvensky, "Denver Housing First Collaborative: Cost Benefit Analysis and Program Outcomes Report," Colorado Coalition for the Homeless; December 11, 2006: retrieved 16 November 2007; http://www.endlongtermhomelessness.org/research_trends_data/knowledge_center/cost_benefit_analysis_program.aspx.

[13] John Billings and Maria Raven, *Improving Health And Health/Social Care Services For High Cost Medicaid Patients*, presentation at Common Ground-NASHP meeting "High Users of Publicly-Funded Health Services: A Strategy for Reducing Spending While Improving Care," held April 24-25, 2007 in New York City.
[14] Maria C. Raven et al., *Identifying and Intervening with Patients at High Risk of Hospital Admission*, presentation at Common Ground-NASHP meeting "High Users of Publicly-Funded Health Services: A Strategy for Reducing Spending While Improving Care," held April 24-25, 2007 in New York City.
[15] FQHCs are federally-funded or designated community health centers, which provide primary and preventive health care to low-income people, 69 percent of whom have incomes below 100 percent of FPL. Nationally, one in four homeless people and one in eight Medicaid beneficiaries receive their health care through FQHCs. All states are required to cover FQHC services in their Medicaid programs.
[16] Mark Trotz, presentation at Common Ground-NASHP meeting "High Users of Publicly-Funded Health Services: A Strategy for Reducing Spending While Improving Care," held April 24 & 25, 2007 in New York City.
[17] San Francisco Department of Public Health, "Direct Access to Housing and Urban Housing Health," 2007, handout, retrieved 21 November 2007;
http://www.dph.sf.ca.us/Reports/Homeless/HomelessSvcsRpt1022004AppendC.pdf.
[18] Common Ground and NASHP, "Pathways to Housing: A consumer choice housing first program: Experimental evidence" handout at "High Users of Publicly-Funded Health Services: A Strategy for Reducing Spending While Improving Care Meeting," held April 24 & 25, 2007 in New York City.
[19] Chicago Housing for Health Partnership. Cited in presentation at Common Ground-NASHP meeting on High Users of Publicly-Funded Health Services: A Strategy for Reducing Spending While Improving Care, April 24 - 25, 2007 in New York City.
[20] The information presented in this discussion is a simplified description of a complex program. For more complete information please refer to the Centers for Medicare & Medicaid Services (www.cms.gov), especially *Medicaid At–a-Glance 2005: A Medicaid Information Source.* Publication No. CMS-11024-05 (Washington, DC: Centers for Medicare and Medicaid Services 2005); retrieved 21 November 2007;
http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/maag2005.pdf.
Another thorough source about federal Medicaid policies is *The Medicaid Resource Book*, (Menlo Park, CA: Kaiser Family Foundation); retrieved 21 November 2007; http://www.kff.org/medicaid/2236-index.cfm.
[21] Waivers are described later in this section.
[22] All information about 1115 waivers is from: Centers for Medicare and Medicaid Services, "Medicaid Waivers and Demonstrations List;"2007; retrieved 21 November 2007;
http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp.
[23] §1915(c)(1) of the Social Security Act (SSA).
[24] Targeted case management or TCM is intended to help a defined group of Medicaid-covered people (e.g., those with serious mental illness or high-risk pregnant women) to obtain the services they need, even if those services are not covered by Medicaid. TCM includes assessment, treatment plan development, activities to obtain needed services, and follow-up services to ensure that the plan is implemented and meets the needs of the individual. Please see P.L. 109–171, §6052 for more information.
[25] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Center for Medicaid and State Operations, "Dear State Medicaid Director" letter June 24, 1998; retrieved 21 November 2007;
http://www.cms.hhs.gov/smdl/downloads/smd062498.pdf.
[26] §1915(b)(2) of the SSA.
[27] §1903(m)(2)(A) of the SSA.
[28] The Medicaid provisions of the DRA are contained in P.L. 109–171, Title VI. The DRA also changed federal rules regarding beneficiary cost sharing and pharmacy reimbursement.
[29] More information about waivers is available at: Centers for Medicare and Medicaid Services, "Medicaid State Waiver Program Demonstration Projects - General Information: Overview;" 2005; retrieved 21 November 2007;
http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/01_Overview.asp.
[30] Despite opportunities, there are challenges to managed care for homeless populations, including requirements that care be provided at specific locations and capitated payments that discourage mainstream providers from spending an additional amount to serve high-cost populations. HHS has published two booklets that offer states guidance on developing and implementing Medicaid managed care programs that include homeless people. For more information see U.S. General Accounting Office, *Homelessness: Barriers to Using Mainstream Resources*, July 2000, GAO/RCED-00-184.

[31] Joanne Rawlings-Sekunda and Neva Kaye, *Emerging Practices and Policy in Medicaid Managed Care for People with HIV/AIDS: Case Studies of Six Programs* (Portland, ME: The National Academy for State Health Policy, 1998).
[32] Wisconsin Department of Health and Family Services, Division of Health Care Financing, "Medicaid Managed Care Programs," 2007, retrieved 21 November 2007; http://dhfs.wisconsin.gov/medicaid7/mc_overview.pdf.
[33] New Mexico Human Services Department, "New Mexico's Behavioral Health Collaborative," 2007, State of New Mexico, retrieved 21 November 2007; http://www.bhc.state.nm.us/.
[34] School of Public Health and Health Services, "Research Activities: Medicaid Contract Purchasing Specifications," 2007, George Washington University, retrieved 26 November 2007; http://www.gwumc.edu/sphhs/departments/healthpolicy/chsrp/newsps/Home/.
[35] Gail Robinson et al., *State Profiles of Mental Health and Substance Abuse Services in Medicaid*. (Washington, DC: SAMHSA, 2005); retrieved 21 November 2007; http://mentalhealth.samhsa.gov/publications/allpubs/State_Med/default.asp.
[36] Ibid.
[37] Information about Medicaid eligibility, benefits, and service delivery to support efforts to access and coordinate services for homeless people is included in: Gary Smith, Human Services Research Institute, *A Primer on How to Use Medicaid to Assist Persons Who are Homeless to Access Medical, Behavioral Health, and Support Services*, prepared for Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, January 2007, http://www.cms.hhs.gov/HomelessnessInitiative/Downloads/HomelessPrimer2007.pdf, retrieved December 2007. See also U.S. General Accounting Office, *Homelessness: Barriers to Using Mainstream Resources*, July 2000, GAO/RCED-00-184.
[38] The Housing First approach differs from traditional emergency shelter or transitional housing approaches in focusing on helping individuals and families quickly access and sustain permanent housing followed by services as needed, which is consistent with desires and assistance requested by most people experiencing homelessness: National Alliance to End Homelessness, http://www.endhomelessness.org/section/tools/housingfirst, retrieved December 2007.
[39] "The Need for Homelesness Prevention: A Doctor's View of Life and Death on the Streets" by James. J. O'Connell, Journal of Primary Prevention 23 June 2007, 28: 199-203.

APPENDIX A: PARTICIPANT LIST

Deborah Bachrach
Medicaid Director
State of New York
and
Deputy Commissioner of Health
Office of Health Insurance Programs

Peggy Bailey
Health Policy Analyst
National Alliance to End Homelessness

Arturo Bendixen
Director
Housing and Health Partnership
and
Associate Director
AIDS Foundation of Chicago

John Billings
Associate Professor of Health Policy and Public Service
Director of the Center for Health and Public Service Research
Wagner School of Public Service

Lisa Falcocchio
Director of Policy and Planning
Common Ground Community

Rosanne Haggerty
President
Common Ground

Kathleen Henry
Director
Health Care Eligibility and Access Division
Minnesota Department of Human Services

Jennifer Highley-Wheeler
Director of Care
Common Ground Community

Laura Kadwell
Director for Ending Long-Term Homelessness
Minnesota

Neva Kaye
Senior Program Director
National Academy for State Health Policy

Cheryl Kennedy-Perez
Manager, Homeless & Housing Services
MA Dept. of Public Health/Bureau of Substance Abuse Services

Tricia Leddy
Chief of Staff
Rhode Island Department of Mental Health, Retardation & Hospitals

Philip F. Mangano
Executive Director
United States Interagency Council on Homelessness

Lisa Mangiante
Deputy Director
Frequent Users of Health Services Initiative
California

George Nashak
Acting Deputy Commissioner for Adult Services
New York City Department of Homeless Services

Thomas W. Nolan, Ph.D.
Senior Fellow
Institute for Healthcare Improvement

John O'Brien
Regional Coordinator, Region I
United States Interagency Council on Homelessness

Gail Rapp
Director
Bureau of Managed Health Care
Division of Health Care Financing
Utah Department of Health

Dr. Maria Raven
Bellevue Hospital
New York

Jill Rosenthal
Program Director
National Academy for State Health Policy

Lloyd I. Sederer, M.D.
Medical Director
New York State Office of Mental Health

Cheryl Harris Sharman
Writer and researcher

Richard A. Sheola
President
ValueOptions Public Sector Division

Rick Surpin
President
Independence Care System
New York

Marc Trotz
Director of Housing and Urban Health
San Francisco Department of Public Health

Dr. Sam Tsemberis
Executive Director
Pathways to Housing
New York

Jamie Van Leeuwen, MA, MPH, CAC III, PhD
Project Manager
Denver's Ten Year Plan to End Homelessness

Elbra Wedgeworth
Chief Government and Community Affairs Officer
Denver Health

David Wilson
Councillor, Chair Community Services
City of Melbourne
Australia