

Creating a Medicaid Supportive Housing Services Benefit: A Framework for Washington and Other States

Dear Medicaid Permanent Supportive Housing Stakeholders:

In recent months, the Washington Low Income Housing Alliance and CSH have worked in collaboration with support from the Washington State Chronic Homeless Policy Academy to produce the attached white paper titled, "Creating a Medicaid Supportive Housing Service Benefit: A Framework for Washington and Other States." We are excited to share the final paper and to work with the broad array of stakeholders over the coming months to further discuss how Washington can improve the health and housing outcomes for people experiencing chronic homelessness, while also creating efficiencies in care coordination and reducing emergency and crisis service utilization.

Permanent supportive housing is a specific affordable housing and service delivery model that is targeted toward people who are highly disabled and are experiencing, or are at risk, of chronic homelessness. This model is nationally recognized as an evidenced based practice and is an effective intervention for individuals who have a serious mental health disorder, chemical dependency disorder, co-occurring disorder, or multiple and complex physical health problems. The model's independent and affordable housing paired with intensive housing-based case management and tenancy support services help people with complex needs recover from illness and live with stability, autonomy, and dignity.

The attached white paper outlines the concept of creating a new **Medicaid benefit** in Washington to cover the **housing-based case management and tenancy support services** provided in permanent supportive housing. The creation of such a benefit would provide funding for medically necessary services delivered in permanent supportive housing and would help bring this model to scale across the state. National and local research has demonstrated that this intervention leads to the following outcomes for people experiencing or at risk of chronic homelessness: 1) improved access to primary and behavioral health care, 2) improved health outcomes and housing stability, and 3) reduced costs to emergency services and public systems, such as health care and jails. We anticipate that the creation of a new Medicaid benefit will strengthen these outcomes, and our white paper outlines the initial steps necessary to create a benefit, as well as preliminary cost modeling.

We look forward to collaborating with the stakeholder community as we continue our work to create to a Medicaid supportive housing services benefit in Washington. Please feel free to contact the Housing Alliance if you have any questions regarding this policy concept or if you would like to be added to our stakeholder list.

Sincerely,

Michele Thomas
Director of Policy & Advocacy



Creating a Medicaid Supportive Housing Services Benefit

A Framework for Washington
and Other States

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About CSH

CSH transforms how communities use housing solutions to improve the lives of the most vulnerable people. We offer capital, expertise, information and innovation that allow our partners to use supportive housing to achieve stability, strength and success for the people in most need. CSH blends over 20 years of experience and dedication with a practical and entrepreneurial spirit, making us the source for housing solutions. CSH is an industry leader with national influence and deep connections in a growing number of local communities. We are headquartered in New York City with staff stationed in more than 20 locations around the country. Visit csh.org or email consulting@csh.org to learn how CSH can make a difference where you live.

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Abstract

This white paper describes the policy and implementation avenues available to Washington State to use its Medicaid resources more efficiently and improve the health outcomes of its most vulnerable residents by creating a Medicaid supportive housing services benefit. Supportive housing combines affordable housing with tenancy supports and housing case management for people who face some of life's most complex challenges. Research shows that supportive housing improves health outcomes and lowers health care and other system costs. The homelessness response system identifies supportive housing as a best practice for ending chronic homelessness, but it does not have the resources needed to take this intervention to scale. Medicaid could pay for the services delivered in supportive housing but a number of barriers prevent it from doing so today.

A Medicaid supportive housing services benefit would remove these barriers and pay for the housing retention services delivered in supportive housing. By creating this benefit, Washington State can address the goals called out in its State Innovation Plan to “improve health, improve care, and reduce costs” and end chronic homelessness (State of Washington, 2013).

Part I of this white paper explains the missing link between health care and supportive housing, the positive impact that supportive housing has on health care, and the need for a Medicaid supportive housing services benefit. Part II provides a description and analysis of five primary considerations that decision makers will need to address in order to implement the benefit.

The material in this paper makes policy and implementation references to the State of Washington, but the opportunity to create a supportive housing services benefit is applicable to all states.

“Rhonda” was an exceptionally high utilizer of local emergency rooms at the time she moved into supportive housing. She has been diagnosed with bi-polar disorder, borderline personality disorder, and alcohol dependence. Rhonda would present extremely intoxicated and complaining of a variety of medical conditions, but when medical staff attempted to address them with her, she grew hostile or violent and left against their advice. This happened multiple times a week, sometimes multiple times a day.

Rhonda had been offered several living options, but all of them required some sort of program participation or treatment compliance, so she refused them all. When she moved into supportive housing, she slowly developed a relationship with her service team. Over time, she agreed to work with staff on steps to take before deciding to call 911. Since moving into supportive housing, she has made far fewer unnecessary 911 calls.



Executive Summary

Too many people in Washington State are homeless and have significant health care needs. Research shows that for a subset of these individuals, supportive housing is the solution. Supportive housing combines affordable housing with tenancy supports and housing case management to help people who face the most complex challenges to live with stability, autonomy, and dignity. The homelessness response system fully embraces supportive housing as a best practice for ending chronic homelessness, but it does not have the resources to take this intervention to scale. Homeless system providers and funders are seeking reliable resources to pay for the services delivered in supportive housing. Medicaid could pay for these services, but a number of barriers need to be addressed for it to do so.

Washington's current Medicaid constructs do not serve the entire population of people who are Medicaid eligible and need supportive housing equally. This is creating inefficiency for the people who need these services, a lack of reliable funding for the providers of supportive housing services, and disproportionate health care costs for people who do not have access to supportive housing. State Fiscal Year (SFY) 2012 data show that 14,285 Medicaid beneficiaries with "any housing needs" who were in the top cost decile had annual health care costs of \$29,584 per person on average. Of this group, 1,412 people had average annual health care costs of \$107,959 per person.

A growing body of research shows that supportive housing can improve health and lower health care costs for people who face some of the most significant barriers to housing and health care. Washington could use its Medicaid resources more efficiently and effectively to address the health care needs of these individuals while furthering its goal of ending chronic homelessness by creating a supportive housing services benefit. This benefit would not pay for housing. It would pay for the housing retention and case management services delivered in supportive housing.

Washington is well-poised to create a supportive housing services benefit. Lawmakers have repeatedly identified housing as an important component of the state's evolving health care delivery system in recent legislation. State agencies have recognized supportive housing as a tool for improving care, improving health, and reducing costs in Washington's State Health Care Innovation Plan. Stakeholders across the state are increasingly engaged in an effort led by the Washington Low Income Housing Alliance to create a Medicaid supportive housing services benefit.

Implementing this benefit will require several considerations on the part of policy makers, state agencies, advocates, managed care entities, and providers of supportive housing services. There are five primary components of implementation that decision makers must take into consideration when creating a Medicaid supportive housing services benefit: beneficiary eligibility, the package of services to be provided, state Medicaid plan changes, financing and reinvestment strategies, and roles and responsibilities of multiple organizations in operationalizing the benefit.



Introduction

Supportive housing combines affordable housing with tenancy supports and housing-based case management to help people who face the most complex challenges to live with stability, autonomy, and dignity. National and local research demonstrates that supportive housing improves health outcomes and reduces health care and other system costs for people who experience homelessness and housing instability.

Part I of this white paper explains the missing link between health care and supportive housing, the positive impact that supportive housing has on health care, and the need for a Medicaid supportive housing services benefit to pay for these services. Part II provides a description and analysis of the five primary components of implementation that decision makers will need to address in order to create the benefit.



Background

Homelessness

The U.S. Department of Housing and Urban Development (HUD) requires communities to submit data on the number of people living within their jurisdictions who are homeless in order to qualify for federal homeless assistance funds.

Washington State most recently reported to HUD that 17,755 persons were counted as homeless on one night in January, 2013 (WA State Department of Commerce, 2013). Of this group, roughly 11

percent were estimated to be chronically homeless. HUD defines an individual as chronically homeless if he or she has a disabling condition and has been homeless for longer than one year or more than four times in the last three years. People who experience chronic homelessness are among the most vulnerable people in the homeless population. They tend to have high rates of behavioral health problems, including severe mental illness and substance use disorders, conditions that may be exacerbated by physical illness, injury, or trauma. Consequently, they are often frequent users of emergency services, crisis response, and public safety systems (National Alliance to End Homelessness, 2014). Sadly, people with serious mental illness are 25 years younger at age of death than the general population, and homelessness is among the avoidable contributors to their vulnerability (Mauer, Parks, Svendsen, Singer, & Foti, 2006).

HUD defines an individual as chronically homeless if he or she has a disabling condition and has been homeless for longer than one year or more than four times in the last three years.

Supportive Housing

Supportive housing combines affordable housing with supportive services that help people who face the most complex challenges to live with stability, autonomy, and dignity. Supportive housing is not affordable housing with resident services. It is a specific intervention for people who, but for the availability of services, do not succeed in housing and who, but for housing, do not succeed in services.

The housing in supportive housing is affordable, permanent, and independent. The services are intensive, flexible, tenant-driven, voluntary, and housing-based. The services in supportive housing are tenancy supports that help people access and remain in housing. Supportive housing is also a platform from which health care services can be delivered and received.

The National Alliance to End Homelessness names supportive housing as the solution to the problem of chronic homelessness (National Alliance to End Homelessness, 2014). The Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services (DHHS) recognizes supportive housing as an evidence-based program for people with behavioral health conditions (SAMHSA, 2014).

Supportive housing apartments should be in healthy communities with access to amenities. There are three housing models of supportive housing. Communities should have a balanced array of models available to allow people who need supportive housing to make choices about where they live. In all three of the following models, tenants hold leases with landlords, or service providers master lease units from landlords and sublet them to supportive housing tenants.

- Scattered-site: Housing is rented anywhere in a community.
- Clustered or integrated: A limited number of units are set aside for people who need supportive housing within a larger rental development.
- Single-site: An entire housing development is prioritized for people who need supportive housing.

Any of these models can work well in urban communities. In suburban or rural communities where densities are lower, scattered-site and integrated housing are the most commonly used models. Affordable housing is paired with an intensive package of services designed to help people remain housed, recover from illness, and increase self-sufficiency. Housing retention services are the core services of supportive housing.

Housing case managers provide direct tenancy supports such as ensuring rent is paid, assisting with furnishings, acquiring cleaning supplies and household items, negotiating with landlords, teaching housekeeping skills, providing conflict resolution among tenants, and community-building activities. They also provide transportation to appointments, assistance with medication adherence, health education, substance abuse services, nutritional counseling, money management, linkages to education



and job training, and care coordination. Case managers connect tenants to teams of professionals that can help them improve their lives, including social workers, certified alcohol and drug addiction counselors, psychiatrists, psychologists, peer support specialists, nurses and doctors, and job training specialists. They also make connections with staffs of hospitals and health clinics when tenants receiving acute medical care are in need of support at home.

Medicaid

Medicaid is public health insurance that provides essential medical and medically related services.

The states and the federal government jointly finance the Medicaid program. In Washington State, the federal matching rate for Medicaid expenditures is 50 percent. The DHHS administers the Medicaid program through the Centers for Medicare and Medicaid Services (CMS). States

must designate a single state agency to be responsible for the Medicaid program; in Washington, this is the Health Care Authority (HCA). The agreement between CMS and the state is called the Medicaid State Plan. Creating a new Medicaid benefit requires making a change to the State Plan, which can be done through amendments and/or waivers of statutory requirements.

When considering how Medicaid might pay for supportive housing services, it is important to remember that first and foremost Medicaid is a health insurance plan, not a social services program. Therefore, Medicaid's ability to reimburse for any service starts with whether the beneficiary has an illness. Although the federal government requires each state to pay for a minimal level of Medicaid benefits, these services focus on primary care and do not include activities such as case management.

Prior to Medicaid expansion in Washington State, Medicaid was an insurance program only for low-income children, pregnant women, and people with disabilities. For these populations, the HCA and Washington State's Department of Social and Health Services have a variety of tailored benefit packages that build upon the basic mandatory benefits established by federal statute. Optional services such as case management, in-home care, mental health services, substance abuse treatment, assistance with activities of daily living, dental care, and rehabilitation services have been created by waivers or Medicaid State Plan Amendments approved by the federal government. These additional benefits do not yet include the package of services delivered in supportive housing.

“Frank,” a man in his 60s, suffered many heart attacks while living on the streets and was in and out of hospitals. When he moved into supportive housing, his housing team immediately connected him with a nurse who began working to get him the heart medication he needed. Unfortunately, Frank did have another heart attack. But this time, his neighbor, another supportive housing tenant, came to visit him shortly thereafter and called 911. Frank was admitted to the hospital, treated, and discharged to return home. His doctors at the hospital said that if he had not been housed, taking medication, and attended to quickly, Frank would likely not have survived this heart attack.

Statutorily, Medicaid insurance cannot pay for room and board directly. Medicaid is focused on improving payment for health-related services and improving connections to the health care system. States establish agency licensing requirements and staff qualifications that determine which health care providers can use Medicaid funds and which services they can provide.

Related Efforts in Washington State

Washington State has increasingly emphasized housing as an integral part of its health care delivery system since the adoption of the Affordable Care Act. Following is a summary of relevant efforts to date.

State Innovation Model: In December 2013, Washington State submitted a State Healthcare Innovation Plan to the Center for Medicare and Medicaid Innovation (CMMI) that was developed under a CMMI planning grant. The plan lays out an ambitious set of strategies for better health, better care, and lower costs. In its description of the current landscape for health care, Washington recognizes itself as a national leader in supportive housing. It also acknowledges the role that supportive housing plays in decreasing Medicaid costs and improving the lives of people who are chronically homeless and have serious mental illnesses.

Health Homes: In 2013, Washington began implementing its Health Home State Plan Amendment to facilitate access to and coordination of a full array of primary and acute physical health services, behavioral health care, and community-based services and supports for anyone with multiple chronic illnesses. (Health homes are not housing. They are virtual networks of providers that collaborate to provide health care to people with high needs and chronic conditions.) Washington identifies housing as a key service of health homes and expects care coordinators working in health homes to link their members to housing. New York and other states are working now to make connections between health home care coordinators and supportive housing service providers.

Strategy 2 “Duals Demonstration Project”: In King and Snohomish Counties, Washington is implementing a federal demonstration program to provide care coordination for people with high needs who are dually-eligible for both Medicaid and Medicare. This initiative also acknowledges the importance of stable housing as a social determinant of health.

State bills 5732/1519 were enacted in 2013 to improve outcomes for adults served by publically funded mental health and chemical dependency services by using evidence-based, research-based, and promising practices. The State Legislature directs the Department of Social and Health Services and HCA to base contract performance measures on, among others, improved health status; reduction in avoidable utilization of and costs associated with hospital, emergency room, and crisis services; and increased housing stability.

Senate Bill 6312, enacted in 2014, changes how Washington State will purchase chemical dependency and mental health services. The legislature directs the state to purchase chemical dependency services through new behavioral health managed care organizations that will provide both chemical dependency and mental health services and to develop the means to better serve people with mental health disorders. The bill specifically authorizes the provision of supportive housing as a component of service delivery.



Part I - The Missing Link between Health Care and Supportive Housing

Homelessness and Health

Many people who experience long-term or multiple episodes of homelessness also have high health care needs and costs. Adults who become homeless, particularly those who experience chronic or long-term homelessness, are far more likely to suffer from chronic medical conditions, such as HIV/AIDS, hypertension, and diabetes, and to suffer complications from their illnesses due to lack of housing stability and regular, uninterrupted treatment (Sadowski, Key, VanderWeele, & Buchanan, 2009). Nationally, in 2010, an estimated 46 percent of adults living in emergency shelter had a chronic substance abuse problem and/or a severe mental illness. For those in supportive housing, 82 percent had a mental or physical disability, more than half had a substance abuse and/or serious mental health condition, and 6.4 percent had HIV/AIDS (U.S. Department of Housing and Urban Development, 2010).

Not surprisingly, for many individuals with complex chronic health conditions, homelessness or housing instability can be the most significant barriers to health care access, often resulting in excessive use of expensive emergency department, inpatient treatment, and crisis services. For these individuals, supportive housing offers an evidence-based solution to improve health outcomes while reducing costs (Nardone, Cho, & Moses, 2012).

A number of studies have drawn correlations between homelessness and high health care costs. A New York study aimed at establishing a methodology to identify persons at the highest risk for continued, frequent hospital admissions found that patients who were homeless or precariously housed were more than six times more likely to name the emergency department as their usual source of care or to say they had no usual source of care than patients who had stable housing (Raven, Billings, Goldfrank, Manheimer, & Gourevitch, 2009). Patients who were homeless or unstably housed were also far more likely to have a hospital admission associated with substance use or related illness. Seventy-three percent of the patients who were homeless or precariously housed were admitted with mental health or substance use-related diagnoses, compared to only five percent of housed patients. In California, the Frequent Users of Health Services Initiative sought to connect people who were high utilizers of emergency departments with care management services and found that approximately 45 percent of these individuals were homeless (Linkins, Brya, & Chandler, 2008).

Patients who were homeless or precariously housed were six times more likely to name the emergency department as their usual source of care or to say they had no usual source of care than patients who had stable housing.

The Boston Health Care for the Homeless program, which followed a cohort of 119 homeless adults, found that these individuals accounted for 18,384 emergency department visits and 871 medical hospitalizations over a five-year period and that they had average annual health care costs of \$28,436 (O'Connell, et al., 2010).

In Washington State, the Department of Social and Health Services Research and Data Analysis (RDA) Division identified State Fiscal Year 2012 health care costs for Medicaid beneficiaries ages 18–64 who were chronically homeless according to social service and homeless assistance service records. The 2,042 chronically homeless Medicaid beneficiaries in SFY 2012 whose health care costs placed them in the top cost decile had average annual health care costs of \$33,459 per person. Of this group, 201 individuals had average annual health care costs of \$117,500 per person. When the definition of homelessness was expanded to include individuals with any indication of housing need, the 14,285 homeless and unstably housed individuals in the top decile based on health care costs were found to have average costs of \$29,584 per person. (Please see Appendix A for more information about this study group).

201 individuals in Washington State who were chronically homeless had average annual health care costs of \$117,500 per person.

Supportive Housing’s Impact on Health Outcomes and System Costs

A growing body of research shows that supportive housing can improve health and lower system costs for people who are highly vulnerable. By providing stable affordable housing, tenancy supports, and housing case management services that connect tenants to a network of comprehensive primary and behavioral health services, supportive housing can help improve health, foster mental health recovery, and reduce alcohol and drug use among formerly homeless individuals.

A supportive housing project in Washington State, 1811 Eastlake, is nationally recognized for its documented success in improving health outcomes and reducing Medicaid costs by serving chronically homeless people in Seattle with severe alcoholism and high use of crisis services. A research study on the project was published in the prestigious *Journal of the American Medical Association* (Larimer, et al., 2009). Ninety-five tenants of 1811 Eastlake had total costs of \$8,175,922 in the year prior to the study, which decreased to \$4,094,291 in the year after enrollment, showing a 53 percent total cost rate reduction for housed participants relative to wait-list controls and historical data on service usage. Total emergency costs for this sample declined by 72.95 percent, or nearly \$600,000 in the two years after the program’s launch. The project also found that supportive housing tenants dramatically reduced alcohol use within 12 months of tenancy (24 percent fewer drinks per day and 65 percent fewer days intoxicated).

An Illinois permanent supportive housing program identified a 39 percent reduction in the total cost of services for residents in the two years after moving into housing (Nogaski, Rynell, Terpstra, & Edwards, 2009). This figure includes services from Medicaid, mental health hospitals, substance use treatment centers, prisons and county jails, and hospitals. Mainstream service costs decreased by almost \$5,000 per person for overall savings of \$854,477 in two years for the 177 participants.

In Rhode Island, a cost study found that supportive housing led to a net savings per person per year of \$8,839 after factoring the costs of both housing and services. Cost savings were realized as a result of reduced visits to emergency rooms and overnight stays in hospitals, mental health and chemical dependency treatment facilities, jails and prisons, and shelters. (Hirsch, Glasser, D’Addabbo, & Cigna, 2008).

A cost benefit analysis of the Denver Housing First Collaborative examined system costs of 19 supportive housing residents for two years prior to, and two years post, housing (Perlman & Parvensky, 2006). The post-period had 34 percent fewer emergency room visits, 40 percent fewer inpatient visits, 82 percent fewer detox visits, and 76 percent fewer incarceration days.

In a comprehensive examination of the evidence on permanent supportive housing's outcomes, Rog, et al. (2013), recommended that policy makers consider including permanent supportive housing as a covered service for individuals with mental illness and substance use disorders.

Studies such as these and the clear connection between housing stability and health are leading states across the country to explore ways to connect supportive housing and health care. In particular, New York has recently received approval of an 1115 waiver that includes a tremendous focus on supportive housing. Rhode Island is awaiting word from CMS on an 1115 waiver renewal request that includes the provision of a supportive housing services benefit. CSH is participating in and tracking many of these efforts and has recently released a status report summarizing state Medicaid policy activities related to supportive housing, which can be found in Appendix C.

Current Barriers to Paying for Supportive Housing Services with Medicaid in Washington State

In 2013, the King County Committee to End Homelessness commissioned CSH to conduct a crosswalk of services that are reimbursable by Medicaid with those that are provided in supportive housing. The goal of the crosswalk was to determine whether Medicaid could pay for supportive housing services, and if not, to identify barriers that need to be addressed in order to do so. The crosswalk demonstrated that although many of the services provided in supportive housing are theoretically coverable by Medicaid for certain populations, a number of barriers prevent supportive housing service providers from accessing Medicaid. Washington's current Medicaid constructs do not serve the entire population of people who need supportive housing equally. This creates inefficiency for the people who need these services, a lack of reliable funding for the providers of supportive housing services, and disproportionate health care costs for people who do not have access to supportive housing. The most significant barriers in today's Medicaid system that prevent the payment of supportive housing services are described below by subpopulation.

1. Barriers to providing Medicaid-financed supportive housing services to people with mental illnesses.

Washington's managed behavioral health care system of regional support networks provides Medicaid services to people who meet access-to-care standards for mental health services through its outpatient mental health system using a service modality called "Individual Treatment." This modality theoretically permits Medicaid to pay for many of the services provided in supportive housing for the subset of people who need them and have mental illnesses. However, outpatient mental health caseloads are large, and there is not enough funding in the mental health system to provide the intensive array of housing retention and

housing case management services that are critical to the success of supportive housing tenants. Caseloads in supportive housing are generally one-to-10 whereas outpatient mental health caseloads are as high as one-to-70. Mental health professionals have limited time to provide services outside of clinics. Although outpatient, clinic-based mental health services are an important component of many supportive housing tenants' service plans, these services alone do not provide the breadth or depth of supports necessary for a subset of people who have mental illness who need supportive housing. In addition, most mental health services are covered only when conducted face-to-face. Services performed on a client's behalf when the client is not present are generally not reimbursable.

2. Barriers to providing Medicaid-financed supportive housing services to people with chemical dependency.

The delivery of chemical dependency services is currently paid through a fee-for-service structure, which limits the range of health-related supports a chemical dependency specialist can provide and requires the documentation of service delivery in 15-minute increments. The Affordable Care Act is moving states away from fee-for-service structures because the payment of individual visits encourages volume as the driver for raising revenue, and it is difficult to comprehensively serve people with complex health conditions under this payment model. The services provided through the Medicaid chemical dependency system are also limited to very specific substance use treatment interventions and do not allow for the myriad of tenancy supports needed to keep someone stably housed and engaged in clinical services. Most chemical dependency services are covered only when conducted face-to-face. Services performed on a client's behalf when the client is not present are generally not reimbursable. In addition, the funding for outpatient chemical dependency treatment is far too limited to pay for the full package of supportive housing services. Fortunately, Washington State is moving toward an integrated delivery system of mental health and chemical dependency services for people with high needs. This system will likely improve service delivery for chemical dependency, but the new system design does not yet address payments for supportive housing services.

3. Barriers to providing Medicaid-financed supportive housing services to people who do not have behavioral health needs.

The only mechanisms that currently exist to pay for supportive housing services are those in the behavioral health system described above. There is no vehicle through which Medicaid can pay for supportive housing services for people who do not have behavioral health needs.

4. Barriers to providing Medicaid-financed supportive housing services to all people who need supportive housing.

A number of barriers apply to all people who need supportive housing. A small portion of supportive housing services are not currently coverable by Medicaid, including outreach, engagement, enrollment, and some transportation costs. Outreach and engagement are critical to moving people from the streets into apartments, and they are needed on an ongoing basis

to encourage tenants to participate in clinical services. Many of the daily living activities in supportive housing require time spent in transit to visit other health care professionals and to help tenants access household items. Supportive housing service providers in scattered-site housing models need to travel to and from tenant's homes to visit with them, check on their well-being, and connect with landlords.

Another barrier is that many supportive housing service agencies are not currently licensed to provide Medicaid services, and the only licensing opportunity available to them is through the behavioral health outpatient system. Most supportive housing providers started as affordable housing or human service agencies that learned the skills and best practices of supportive housing over many years. These agencies do not necessarily all want, or need, to become fully licensed behavioral health providers. To bring the expertise of these agencies to the health care system, Medicaid licensing and certification is needed for the specific provision of supportive housing services.

Creating a Medicaid Supportive Housing Services Benefit

Creating a Medicaid supportive housing services benefit will provide a mechanism through which Medicaid can pay for supportive housing services for individuals who are eligible for Medicaid.

Implementing this benefit will enable Washington State to use its Medicaid dollars more efficiently to address the serious health conditions of its most vulnerable residents and act on its goal to end chronic homelessness.

Washington has a track record of recognizing the importance of stable housing in health care, and stakeholders across the state are increasingly engaged in an effort led by the Washington Low Income Housing Alliance to create a Medicaid supportive housing services benefit. (Please see Appendix B for an overview of stakeholder participation to date.) Implementing a Medicaid supportive housing services benefit will require several considerations on the part of policy makers, state agencies, advocates, managed care entities, and providers of supportive housing services. Part II explains the five components of implementation.

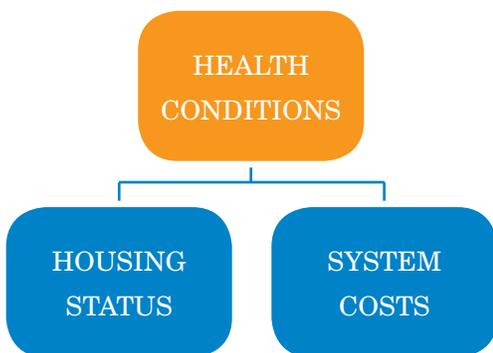
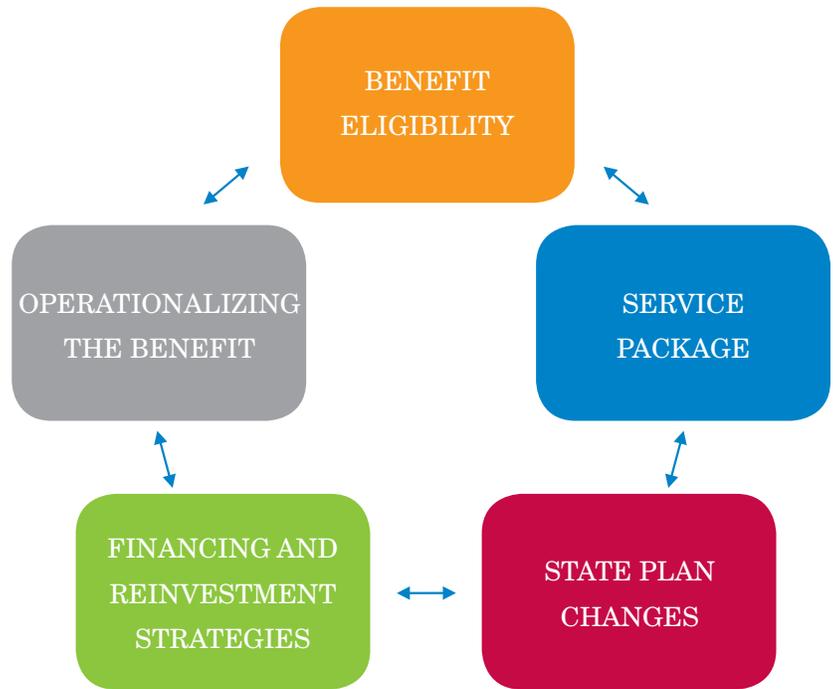


Part II - Implementation

There are five primary components of implementation that decision makers must address to create a Medicaid supportive housing services benefit: benefit eligibility, the package of services to be delivered, state Medicaid plan changes, financing and reinvestment strategies, and the roles of managed care and supportive housing service providers in operationalizing the benefit.

It is important to note that these components of implementation are interdependent. For example, the amendments or waivers the state adopts to change its Medicaid plan can dictate eligibility criteria for the population to be served by the supportive housing services benefit. Eligibility for the benefit may also be influenced by the projected return on investment (ROI) for different subpopulations. Each of the five points of decision making must be considered independently and within the context of the others.

FIVE COMPONENTS OF BENEFIT IMPLEMENTATION



1. Benefit Eligibility

This benefit is not intended to serve everyone who could generally benefit from affordable housing paired with non-housing based services, and/or “resident services.” It must be targeted to people who are eligible for Medicaid and in need an intensive set of housing-based supports to remain stably housed in the community. Eligibility requirements can be established by choosing criteria from three categories that “screen-in” people who need the benefit most: health conditions, housing status, and current or potential system costs.

Health Criteria

Only people who are eligible for Medicaid services on the basis of medical necessity will be eligible for the supportive housing services benefit. Health eligibility criteria can be based on any one, or a combination of, the following conditions:

- Primary severe and persistent mental illness (SPMI)
- Primary mental health diagnosis but not at the SPMI level
- Primary substance use diagnosis
- Chronic illness
- Complex health needs (disability, at risk of institutional care, or multiple chronic illnesses)

Housing Status Criteria

Benefit eligibility criteria will need to include housing status to ensure that the benefit serves only those people who need supportive housing services (as opposed to general affordable housing and/or other non-housing based services or “resident services”). Specifically, eligibility criteria could be based on any, or all of, the following housing situations:

- Chronically homeless (HUD definition)
- At risk of chronic homelessness
- Homeless
- Unstably housed (“any housing need as defined in Appendix A)
- Living in institutions or at risk of institutional care
- Currently living in supportive housing

Washington State Research and Data Analysis Division’s analysis provides an initial indication of health care and housing needs based on a population of clients ages 18–64 who were served in SFY 2012, as shown in Tables 1 and 2 below. Please see Appendix A for the details on this study population and a description of the chronic illness risk score.

TABLE 1: Health conditions of individuals who were “chronically homeless” and whose health care costs were in the top decile.

Total clients	No behavioral health needs	Mental illness only	Substance abuse only	Both mental illness and substance abuse	Chronic Illness risk score ≥1
2,042	5.7%	18.6%	7.8%	67.9%	46.1%
	117	379	160	1,386	942

TABLE 2: Health conditions of individuals with “any housing needs” whose health care costs were in the top decile.

Total clients	No behavioral health needs	Mental illness only	Substance abuse only	Both mental illness and substance abuse	Chronic Illness risk score ≥1
14,285	8.9%	25.9%	6.6%	58.6%	41.5%
	1,268	3,703	936	8,378	5,928

System Cost Criteria

One goal for the benefit is to ensure people receive the care they need in the most effective and efficient way possible. Cost criteria can be used to identify people who are frequent users of, or at risk of, becoming frequent users of public systems who need supportive housing. RDA's analysis shows average per person health and behavioral health care costs of \$33,459 in SFY 2012 for chronically homeless individuals in the top cost decile. Somewhat surprisingly, Medicaid beneficiaries with "any housing needs" who were in the top cost decile had similar annual health care costs of \$29,584 per person on average, as shown in Tables 3 and 4 below.

TABLE 3: Health care costs of individuals who were "chronically homeless" whose costs were in the top decile.

Total clients	Total costs	Average cost per client
2,042	\$68,323,055	\$33,459

TABLE 4: Health care costs of individuals who had "any housing needs" whose costs were in the top decile.

Total clients	Total costs	Average cost per client
14,285	\$422,601,413	\$29,584

In addition to current cost data, communities are finding that using a predictive algorithm is an effective way of identifying people who have high needs before their costs reach an unnecessarily elevated level. Decisions will need to be made as to whether system utilization and cost criteria should apply to other expensive public institutions such as long-term care, jails, and prisons. For example, it may be advantageous to target people in need who are high utilizers of other systems, who have one or more health conditions, and who are homeless.

Eligibility criteria need to be expansive enough to ensure that everyone who needs supportive housing services has access to them and narrow enough to ensure that the benefit is targeted to those who need it most.

Choosing only one criterion, such as chronic homelessness, could exclude a population of people who would otherwise be determined to be in great need of supportive housing services based on multiple criteria. For example, it is likely that many of the 14,285 people who the state identified as having any housing needs and who are in the top decile of health care costs

have a significant level of housing instability among their barriers to better health, and the system will not meaningfully alter their health outcomes without access to supportive housing. The table on the next page offers two examples of how criteria from each category can be combined to create multiple benefit eligibility scenarios.

Sample combination of criteria from each of the three eligibility categories

Health Condition	Housing Status	System Costs
Any	Any	More than \$25,000 per year
Any	Chronically Homeless	Any
Behavioral Health Diagnosis	Unstably housed	Any

Summary: It will be important to establish specific eligibility criteria within three categories of need—health conditions, housing status, and system costs—to ensure the benefit serves those who need it most. It will also be important to solicit additional stakeholder input about this important decision.

2. The Package of Supportive Housing Services

A core feature of services delivered in supportive housing is that they are housing-based. Stable housing provides a foundation from which all other services can be delivered and received. Housing retention services are individualized and based on the applicant or tenant’s needs. They are most often provided at the tenants home. Housing case managers have low caseloads and work closely with other professionals to create a team of supports. Table 5 summarizes the tenancy supports and core case management functions provided in supportive housing for people who need these services in a housing-based model.

TABLE 5: Supportive Housing Services

TENANCY SUPPORTS	HOUSING CASE MANAGEMENT
Outreach and engagement	Service plan development
Housing search assistance	Coordination with primary care and health homes
Collecting documents to apply for housing	Coordination with substance use treatment providers
Completing housing applications	Coordination with mental health providers
Subsidy applications and recertifications	Coordination of vision and dental providers
Advocacy with landlords to rent units	Coordination with hospitals/emergency departments
Master-lease negotiations	Crisis interventions and Critical Time Intervention
Acquiring furnishings	Motivational interviewing
Purchasing cleaning supplies, dishes, linens, etc.	Trauma Informed Care
Moving assistance if first or second housing situation does not work out	Transportation to appointments
Tenancy rights and responsibilities education	Entitlement assistance
Eviction prevention (paying rent on time)	Independent living skills coaching
Eviction prevention (conflict resolution)	Individual counseling and de-escalation
Eviction prevention (lease behavior requirements)	Linkages to education, job skills training, and employment
Eviction prevention (utilities management)	Support groups
Landlord relationship maintenance	End-of-life planning
Subsidy provider relationship maintenance	Re-engagement

Summary: Services covered by the benefit should be distinguished by their focus on housing retention and low caseloads. Because people who have been homeless for many years are not likely to seek services, outreach and engagement must be funded. The benefit service package should be as adaptable as possible to ensure it follows the best practice approaches of tenant-centered, flexible care.

3. State Medicaid Plan Changes

To implement the benefit and receive federal funding to support it, Washington State will need approval from CMS to make changes to its State Medicaid Plan. States can apply to CMS for state plan amendments and/or waivers of federal statutory requirements. It should be noted that implementing more than one amendment or waiver might be required to reach the entire population of people who are determined to be in need of and eligible for the benefit. It will also likely be necessary for Washington to request a 1915b waiver and/or 1932a State Plan Amendment or amend its existing amendments and waivers that created Washington's managed care systems. Any approach the state chooses will require approval from CMS. The application should lay out the core components of change and leave room for negotiation.

There are three state plan options that offer the most significant opportunities for Washington State to create a Medicaid supportive housing services benefit, the Home and Community-Based Services (HCBS) State Plan Amendment (1915i), the HCBS Waiver (1915c), and the 1115 Waiver. These options are described below with an analysis of opportunities and limitations as they relate to creating a supportive housing services benefit.

Home and Community-Based Services

HCBS allow Medicaid beneficiaries with disabilities to receive services in their own home or community as an alternative to costly institutional care such as nursing homes. States offer HCBS to individuals whose eligibility relates to services otherwise provided in a nursing facility, intermediate care facility, or hospital.

“Thomas” had been homeless multiple times and for several years at a time before he met the Housing First outreach team. He had severe health issues including emphysema, and he had a very difficult time getting around because he was chronically inebriated.

Thomas didn't want to accept help because he feared that he'd have to do something in return. His first question was, “Are you going to make me go to rehab?” His second was, “Will I be expected to participate in religious programs?” Even after hearing that the answers to his questions were “no,” he was still wary and said, “I'll see how others do and then maybe...”

The outreach team worked to keep track of where Thomas was and spent time getting to know him so that he would trust them. After a few months, Thomas began to feel more comfortable with the team, and once the cold weather set in he took them up on their offer for housing.

When a unit was ready for Thomas, staff went out and climbed down under the Renton library where he was bundled up, asleep. The team woke him up, helped him pack his belongings, loaded up a truck, and took him to his apartment. When his housing case manager handed him his apartment keys, Thomas teared up and said, “I haven't had my own keys in 9 years.”

CMS recently released its final rule on qualified home and community-based settings, which requires that settings must:

- Be integrated within and support full access to the greater community
- Be selected by the individual from among setting options
- Ensure individual rights of privacy, dignity, and respect, and freedom from coercion and restraint
- Optimize autonomy and independence in making life choices
- Facilitate choice regarding services and who provides them

The final rule also describes requirements for provider-owned or controlled home and community-based residential settings. These requirements include:

- The individual has a lease or other legally enforceable agreement providing similar protections.
- The individual has privacy in their unit including lockable doors, choice of roommates, and freedom to furnish or decorate the unit.
- The individual controls his/her own schedule, including access to food at any time.
- The individual can have visitors at any time.
- The setting is physically accessible.

These parameters parallel many of the best practices of permanent supportive housing as promoted in CSH's Dimensions of Quality Supportive Housing. In addition, the U.S. Interagency Council on Homelessness identifies HCBS as, "one of the most promising ways that States can use Medicaid to cover many of the services delivered in permanent supportive housing for people experiencing chronic homelessness" (U.S. Interagency Council on Homelessness, 2014). There are two ways to use HCBS to create a supportive housing services benefit: a HCBS 1915i State Plan Amendment and a HCBS 1951i Waiver.

[HCBS 1915i State Plan Amendment](#)

CMS will allow states the option to provide HCBS benefits for specific populations through a state plan amendment, so long as the state can meet all of the federal requirements of HCBS, which include:

- Beneficiaries must be elderly individuals or people with disabilities.
- Beneficiaries must have incomes not more than 150 percent of the federal poverty level or up to 300 percent of Social Security Income.
- Beneficiaries must meet access to care criteria that is less than that of institutional care.
- Beneficiaries must have choice in providers.
- The state must meet a comparability standard to demonstrate that services are provided to all eligible beneficiaries and cannot be limited based on diagnosis, type of illness, or condition.
- The benefit must be implemented state-wide.
- The state must serve all beneficiaries who meet the benefit's eligibility criteria. (The State cannot limit the number of people who will be served.)
- The state must demonstrate to the federal government that it can provide its share of the cost of the program (without using other federal resources).

Opportunities: The 1915i HCBS State Plan Amendment requires states to serve people with disabilities as defined by the state. Under this amendment, Washington State would be able to serve a large percentage of current and potential supportive housing residents. The 1915i's broad population target, intention to connect people to community-based housing and services, and lack of a federal cost-neutrality requirement make this option very attractive. This option, if coupled with a 1915b Managed Care Waiver, could align well with the state's emerging managed care model for Medicaid.

Limitations: It is important to note that Washington State would have to establish needs-based criteria for eligibility that is based on medical necessity or risk and does not include descriptive characteristics of the person, his/her diagnosis, or general population characteristics (such as homelessness). Eligibility criteria would relate to behavior, cognitive abilities, medical risk factors, or function level. Supportive housing providers would need to alter their current client assessment practices because the agencies that deliver these HCBS services cannot perform the needs assessment. Other Medicaid options might be needed to supplement the plan amendment in order to serve supportive housing residents who do not meet the needs-based criteria.

HCBS 1915c Waivers

States that want to implement the HCBS optional benefit but want to modify one or more of its federal requirements can apply for a 1915c Waiver. A key distinguishing factor of the 1915c Waiver is that beneficiaries must meet access to care criteria of institutional care (although they may or may not be living in institutional care).

The following Medicaid requirements can be waived under 1915c:

- The state may waive the state-wideness criteria and allow for implementation only in specific geographic areas.
- The state may limit the number of people to be served.

Opportunities: A 1915c Waiver is a good tool for creating service packages for people who are institutionalized or at risk of institutionalization such as extremely high-cost, frequent hospital users. The package of services established under an HCBS "c" Waiver could include some of the services in supportive housing that are not typically Medicaid-reimbursable, such as pre-tenancy outreach and engagement supports and specific tenancy supports such as transportation. States that are concerned about the costs of serving large numbers of beneficiaries in a new way could limit implementation to specific geographic areas and/or establish a cap on the number of eligible beneficiaries.

Limitations: Supportive housing services under the 1915c Waiver would only be available to people who are living in an institution and those who, without the services of this waiver, would require the level of care provided in a hospital, nursing facility, or intermediate care facility. This waiver would work well for populations who need supportive housing in order to leave institutional settings, but it could limit the number of people experiencing homelessness who could be served, because most people who are homeless do not require this level of care. All Medicaid waivers are time-limited and must be reapplied for upon expiration. Initial approvals are generally for three years and renewals are five years. Waiver services

must be cost-neutral to the federal government; this means that the per-participant expenditures for the waiver and non-waiver services are no more than the average per-person cost of providing institutional care (and other plan services) to persons who require the same level of care.

1115 Waivers

1115 Waivers offer broad flexibility to change the Medicaid state plan. They allow states to explore innovations in the delivery of care and to pay for services not typically covered by Medicaid. The federal government allows these costs to be covered under an 1115 Waiver as a way of testing their impact on health outcomes and costs. States may also target specific populations for receipt of 1115 Waiver services. One way the federal government limits risk in granting sweeping changes through 1115 Waivers is the federal cost-neutrality requirement that all waivers have (though some limited exceptions are made). Under an 1115 Waiver, states can also alter financing for services. For example, services can be billed through bundled payments rather than through fee-for-service. Another feature of the 1115 Waiver is a requirement that states evaluate their innovations, which can provide valuable input into federal Medicaid policy.

Opportunities: The high level of flexibility available through 1115 Waivers could allow Medicaid to pay for services in supportive housing in a variety of ways. States can target specific populations and ensure they receive services not typically reimbursed by Medicaid. This type of waiver would allow for an innovative program design with the ability to pay for certain critical tenancy supports that help people access and remain in housing. Washington State's strong capacity in data collection and analysis positions it well for the evaluation component of an 1115 Waiver and offers the potential for the state to demonstrate the effectiveness of the supportive housing services benefit to other states.

Limitations: Ironically, a limiting factor in considering an 1115 Waiver is the extensive flexibility it offers. Because states have a wide range of possibilities to consider in applying for an 1115 Waiver, the level of decision making required is greater. Washington State would need to define the population and the services package while demonstrating federal cost-neutrality. This task is likely easier in Washington

Home and Community-Based Services/ Supportive Housing Example: Louisiana

Louisiana has made significant efforts to redesign its delivery and financing of HCBS using multiple 1915 waivers and the 1915i State Plan Amendment. The HCBS services are managed by the behavioral health managed care organization Magellan. The state's goals are to address chronic homelessness, reduce the number of people residing in institutional care (such as nursing homes), and improve the integration of developmental disabilities services, behavioral health, primary care, and housing. Louisiana has defined eligible populations as Medicaid beneficiaries who have a significant, long-term disability; who are receiving services from the Department of Health and Hospitals; and who are in need of housing and support services. Magellan manages the supportive housing providers, tracks availability of units, and reimburses supportive housing service providers for case management and other housing-oriented services. This work will result in nearly 3,000 new units of supportive housing (primarily in scattered-site models).

than in other states, because Washington is one of the few states that tracks homelessness and housing status within the Medicaid program. The state would be required to evaluate the waiver’s success, demonstrate outcomes for beneficiaries, and re-apply for the waiver regularly to maintain this level of flexibility.

Summary: The following chart summarizes key considerations of each of the three state plan options that are best suited to creating a supportive housing services benefit.

1115 Waiver State Example: Illinois

Illinois has submitted an 1115 Waiver that largely seeks to change its Medicaid management from fee-for-service to a managed care system. This waiver application recognizes the need to reduce Medicaid costs through improvements in targeting patients who are highly vulnerable and have high-health care cost. To this end, one of the Waiver provisions would provide managed care entities with incentive payments based on performance measures. The state is seeking CMS approval to allow managed care organizations to re-invest these incentive payments into supportive housing services, rental assistance, and/or capital development. Illinois expects negotiations with CMS to during the summer of 2014.

State Plan Options Best Suited to Creating a Supportive Housing Services Benefit

Plan Option	HCBS 1915i State Plan Amendment	HCBS 1915c Waiver	1115 Waiver
Brief Description	Home and Community-Based Services	Home and Community-Based Services	Flexible waiver for demonstration programs to pilot innovative care delivery models that differ from federal rules
Eligible/Covered Populations	Beneficiaries with disabilities requiring HCBS who meet approved “needs-based criteria” but who are not necessarily at risk of institutionalization	Beneficiaries leaving or at risk of institutionalization	Any Medicaid-eligible beneficiary
Considerations	Must offer coverage statewide; cannot restrict targeting by geography. No federal cost neutrality requirement.	Narrow eligibility parameters. Subject to cost-neutrality.	High standards for evaluation methods that will demonstrate better outcomes and lower costs.

4. Financing and Reinvestment Strategies

A key consideration for decision makers will be the amount of upfront investment needed to create the benefit, the estimated return-on-investment, and strategies for using cost savings to end chronic homelessness.

Financing Considerations

Establishing estimates on the initial investment that will be required to create the benefit, the ability to meet federal cost-neutrality requirements, and the potential return-on-investment for serving specific subpopulations will require an in-depth analysis that accounts for all of the parameters of the benefit. Following is a list of factors that should be considered in financial models for the benefit, along with a brief description of the information that is available today.

TABLE 6: Financing Considerations

FACTORS	INFORMATION KNOWN/UNKNOWN
1. The health care costs and housing status of current beneficiaries.	State Fiscal Year 2012 data is available. (See Appendix A for details.) Beginning in SFY 2013, health care costs reflecting patient-level utilization for Social Security Income (SSI) clients are no longer readily available to the state because these clients are now served through managed care rather than fee-for-service Medicaid.
2. The degree to which costs are impactable (e.g., repeated emergency room visits are likely impactable whereas the cost of dialysis for kidney treatment is not).	This information is not readily available, although some educated estimates can be made based on the types of health care costs seen within the SFY 12 study group.
3. The degree to which accurate and up-to-date information on housing status is available for current beneficiaries.	On average, approximately 20 percent of individuals in Washington State with services recorded in the Homeless Information Management System (HMIS) do not provide consent to also have their identifying information recorded in that system. However, de-identified data from other service systems can often be used to supplement information available through HMIS.
4. The health care costs of current residents of supportive housing.	This information is not yet available, though to some degree, one can assume that the homeless assistance system has largely already reduced the health care costs for these potentially eligible individuals and that ongoing service funding will be needed to keep them housed.
5. The health care costs of the Medicaid-expansion population.	This data is not available because the expansion population has not yet had one full year of Medicaid coverage. (This data will likely soon need to come from Managed Care.)
6. The potential impact on costs to other systems such as jails, long-term care, and treatment facilities.	Additional research could be done to estimate current costs and potential impacts.
7. The affordable housing investments that can be leveraged to create new units of supportive housing.	Although the most immediate challenge in taking supportive housing efforts to scale lies in the lack of service funds, further analysis on the need for housing dollars will inform the number of new supportive housing units that could be created annually.
8. The amount of flexible service dollars available to cover what Medicaid cannot.	Medicaid should pay for as much of the supportive housing service package as possible, but it is not the only source of service funds that will be needed. The homeless assistance system will continue to need to pay for coordinated access systems, program evaluations, building security, services that Medicaid cannot cover, and services for people who are not Medicaid-eligible.

Preliminary Financial Modeling

In its July 2013 Informational Memo, the federal Center for Medicaid and Children’s Health Insurance Program Services (a division of CMS) suggested that states can conduct a simple sensitivity analysis—comparing low, medium, and high estimates of both initial investments and potential savings when establishing a program that addresses the needs of high-utilizers of emergency departments and hospital admissions. In order to perform a similar analysis on the potential impact of the supportive housing services benefit, CSH created three theoretical investment models. Although much of the information in the chart above is not available, these initial investment models can provide a preliminary window into the potential costs and savings of creating a supportive housing services benefit. These models are based on the following assumptions:

- **Medicaid costs:** Health care costs are based on the SFY 2012 study group described in Appendix A.
- **Benefit cost:** The model assumes a capitated rate of \$5,400 annually for the benefit (\$450/monthly).
- **Cost impact:** The model assumes (based on the evidence described in Part I of this paper) that health care costs of the individuals served in supportive housing will decrease by 19 percent.

Supportive Housing Services Benefit Investment Model 1

Based on FY12 costs of 2,042 chronically homeless individuals with average annual healthcare costs of \$33,459.	Average Per Beneficiary	2,042 Beneficiaries
A. Monthly Medicaid Costs (average annual costs divided by 12) State Share of Medicaid Costs (50% State/50% Federal)	\$2,788 \$1,394	\$5,693,607 \$2,846,803
B. Supportive Housing Cost Reduction Estimate	19%	19%
C. Monthly Medicaid Offsets Projected from Supportive Housing (A*B) State Share of Monthly Offsets from Supportive Housing	\$530 \$265	\$1,081,785 \$540,893
D. Monthly Cost of Supportive Housing Services Benefit State Share of Cost of Supportive Housing Services Benefit	\$450 \$225	\$918,900 \$459,450
E. Net Monthly Savings (C-D) State Share of Net Monthly Savings	\$80 \$40	\$162,885 \$81,443
F. Net Annual Savings (E*12) Net Annual State Savings	\$957 \$479	\$1,954,622.82 \$977,311
G. Return on Investment		18%

Supportive Housing Services Benefit Investment Model 2

Based on FY12 costs of 5,928 individuals with “any housing need” who had a chronic illness risk score of ≥ 1 *	Average Per Beneficiary	5,928 Beneficiaries
A. Monthly Medicaid Costs (average annual costs divided by 12) State Share of Medicaid Costs (50% State/50% Federal)	\$2,465 \$1,233	\$14,614,288 \$7,307,144
B. Supportive Housing Cost Reduction Estimate	19%	19%
C. Monthly Medicaid Offsets Projected from Supportive Housing (A*B) State Share of Monthly Offsets from Supportive Housing	\$468 \$234	\$2,776,715 \$1,388,357
D. Monthly Cost of Supportive Housing Services Benefit State Share of Cost of Supportive Housing Services Benefit	\$450 \$225	\$2,667,600 \$1,333,800
E. Net Monthly Savings (C-D) State Share of Net Monthly Savings	\$18 \$9	\$109,115 \$54,557
F. Net Annual Savings (E*12) Net Annual State Savings	\$221 \$110	\$1,309,376 \$654,688
G. Return on Investment	4%	

*Model 2 is based on average annual cost per person of \$29,584, which reflects the average cost per person across all 14,285 individuals in the top cost decile. The subset of that population (n=5,928) who had chronic illness risk scores at or above one (1) would likely have higher average costs than what was used for these estimates.

Supportive Housing Services Benefit Investment Model 3

Based on FY12 costs of 14,285 individuals with “any housing need”	Average Per Beneficiary	14,285 Beneficiaries
A. Monthly Medicaid Costs (average annual costs divided by 12) State Share of Medicaid Costs (50% State/50% Federal)	\$2,465 \$1,233	\$35,216,784 \$17,608,392
B. Supportive Housing Cost Reduction Estimate	19%	19%
C. Monthly Medicaid Offsets Projected from Supportive Housing (A*B) State Share of Monthly Offsets from Supportive Housing	\$468 \$234	\$6,691,189 \$3,345,595
D. Monthly Cost of Supportive Housing Services Benefit State Share of Cost of Supportive Housing Services Benefit	\$450 \$225	\$6,428,250 \$3,214,125
E. Net Monthly Savings (C-D) State Share of Net Monthly Savings	\$18 \$9	\$262,939 \$131,470
F. Net Annual Savings (E*12) Net Annual State Savings	\$221 \$110	\$3,155,269 \$1,577,634
G. Return on Investment	18%	

Initial Financing and Return on Investment

The models above suggest that in order to serve a subset of individuals who were identified in the top decile of health costs, an initial investment of between \$5 and \$38 million would produce a return-on-investment for the Medicaid program, use Medicaid resources more efficiently, and reduce chronic homelessness. The amount of actual initial investment and potential cost savings will vary based upon the number of people to be served and their current or future costs. If cost-savings are to be achieved, they must be reinvested into the supportive housing system in order to take this intervention to scale to end homelessness for highly vulnerable people. In its Health Care Innovation Plan, Washington State proposes that local Accountable Communities of Health can play a role in negotiating how savings will be distributed and reinvested from innovative funding mechanisms that enable cross-sector investment in projects such as supportive housing that have anticipated future ROI. Any savings that the state and managed care organizations (MCOs) achieve could be used to pay for services, housing subsidies, or both.

Summary: Although more data and analysis are needed to create a detailed financial model for the benefit, initial data on health care costs and housing status suggest there are thousands of people in Washington State who have high health care costs and housing instability who could benefit from supportive housing. National and local research demonstrates that when investments are made in supportive housing, overall system costs are reduced and health outcomes improve. The models above suggest that the state could streamline its use of Medicaid dollars to pay for the health care services of more people who have significant needs. In addition to achieving a likely ROI, the benefit would accelerate the state's ability to end chronic homelessness. An important next step in developing the benefit will be to conduct an in-depth financial analysis that accounts for the factors in Table 6. Any cost-savings realized by the benefit must be reinvested to end chronic homelessness.

5. Putting the Benefit into Practice

The State of Washington must take a leadership role in investing in supportive housing, creating accountability measures, and ensuring that cost savings are reinvested to address its goal of ending chronic homelessness. In addition, the benefit must be administered in a coordinated manner with other Medicaid and human service programs. Managed care and supportive housing service providers will play important roles in operationalizing the benefit.

The Role of Managed Care

When the benefit is created, Washington State will need to amend its contracts with MCOs. Within the state, there are two managed care systems, one for primary care and one for mental health (soon to include both mental health and chemical dependency). The benefit could be included in any or all of these contracts. The state will need to pay MCOs an adequate capitated rate for the benefit and incentivize them to meet the performance measures related to health outcomes, cost reductions, and housing stability that have been authorized by recent legislation. The state and MCOs will also need to set up a system through which cost-savings are measured and reinvested into supportive housing. New regional accountable communities of health can play a role in managing this reinvestment strategy.

MCOs will contract with providers of supportive housing services to deliver benefit services. The rates that each health plan will pay each provider for these services will be negotiated on a case-by-case basis. MCOs should seek to work with supportive housing providers that have a solid track record in providing supportive housing services. Cross-training between managed care and supportive housing agencies will be a helpful way to ensure solid working relationships from the start.

The Role of Supportive Housing Service Providers

Nonprofit supportive housing providers across Washington State have a tremendous amount of knowledge and experience in serving people with complex needs and long histories of housing instability. There are many nuances to combining housing retention services with care coordination in ways that ensure people remain in their homes and/or are able to move when needed in order to stay housed.

Some supportive housing providers in Washington are familiar and experienced with Medicaid because they provide outpatient mental health and/or chemical dependency services. Others are experienced supportive housing service providers that will need to consider whether they want to take on Medicaid's licensing requirements or choose to establish more formal partnerships with service agencies that can access Medicaid.

Within the behavioral health system, a new type of licensing has been created that could be very useful in implementing the supportive housing services benefit. Commonly referred to as "limited-scope licensing," this provision allows providers of Medicaid services to become licensed to provide a limited set (or perhaps only one) Medicaid service. Agencies would still need to meet the core Medicaid administrative responsibilities to take on this type of licensure. The Washington Low Income Housing Alliance is working with Washington's nonprofit supportive housing providers to further explore this potential avenue for implementing the supportive housing services benefit.

Coordination with Existing and Emerging Systems

The benefit will work in concert with other Medicaid programs such as health homes and long term services and supports provided through the DSHS Aging and Long Term Supports Administration (AL TSA). The state's health homes demonstration program provides care coordination for people with high levels of need. This level of care coordination coupled with housing case management and tenancy supports can create the team-based approach that is needed to help people who have multiple needs and barriers to housing and healthcare to remain in housing and improve their health. New York offers one example of emerging coordination between health homes and supportive housing.

Approximately 50,000 Washington State adults currently receive long term services and supports; roughly 36,000 of those adults receive in home personal care services to help with such things as preparing meals, personal care (e.g. bathing, dressing), and housekeeping . Coordinating existing long term supports for people who have housing stability as a result of supportive housing will benefit all service providers and the people these programs serve. Further analysis should be conducted to determine how many clients currently receiving AL TSA services could benefit from supportive housing services, and how many of those already receiving supportive housing services have, or are eligible for, long term services and supports.

Summary: The benefit creates many opportunities for collaboration between Washington State, MCOs, supportive housing service providers, and existing and emerging Medicaid programs. Cross-training among these systems will be important to ensure coordination and solid working relationships. The state should explore ways to ensure the agencies with track records for providing supportive housing services can be licensed to provide them under Medicaid, and supportive housing service providers should consider becoming licensed to provide Medicaid services.



Conclusion

Research demonstrates the positive impact that supportive housing has on health outcomes and public system costs when it serves people with complex needs. The homeless assistance system has long recognized supportive housing's unique ability to end chronic homelessness, yet it is unable to take this intervention to scale without dedicated resources to pay for the tenancy supports and housing-based case management services delivered in supportive housing.

Washington State can use the Medicaid dollars it spends on the subset of people who need supportive housing more efficiently by paying for supportive housing services. Implementing a supportive housing services benefit requires five key considerations on the part of policy makers, state agencies, advocates, managed care organizations, and providers of supportive housing services.

- 1. Eligibility:* Criteria should be considered within three categories of need— health conditions, housing status, and system costs—to ensure the benefit serves those who need it most.
- 2. Services:* The package of services covered by the benefit should be distinguished by their focus on housing retention and housing-based case management.
- 3. State Plan Changes:* The 1915i State Plan Amendment offers the opportunity to implement home and community-based services state-wide without limits on the population to be served so long as they meet needs-based criteria. The 1115 Waiver offers significant flexibility to implement the benefit so long as implementation is “cost neutral” to the federal government and evaluations are performed to demonstrate outcomes. Any state plan changes will require companion changes to the state’s managed care plan amendments and/or waivers and CMS approval.
- 4. Financing and reinvestment strategies:* An upfront investment in the benefit will use state dollars more efficiently and likely produce a return-on-investment. An important next step will be to conduct an in-depth financial analysis that takes into account the population to be served, parameters of state plan changes, and a reinvestment strategy that takes the state’s efforts to end chronic homelessness to scale.

5. *Operationalizing the benefit*: The State of Washington must take a leadership role in investing in supportive housing, creating accountability measures, and ensuring that cost savings are reinvested to end chronic homelessness. This direction will set the tone for the important roles of the MCOs and supportive housing service providers that will operationalize the benefit.

Recent legislation and the State Health Care Innovation Plan pave a path for creating a supportive housing services benefit in Washington State, and stakeholders are increasingly engaged in an effort led by the Washington Low Income Housing Alliance to advocate for the creation of the benefit. The Medicaid supportive housing services benefit is an important tool that will allow the state of Washington to use its resources more strategically, accelerate its effort to end chronic homelessness, and provide its most vulnerable residents with stability, autonomy, and dignity.



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Appendix A: Study Population and Measures Used by the Research and Data Analysis (RDA) Division of the Department of Social and Health Services (DSHS) in Data Sample of Washington State DSHS Clients

Study Population

The study population included all individuals with at least one month of Medicaid coverage in State Fiscal Year (SFY) 2012 (July 2011–June 2012), including those with dual Medicare status. Health care costs were identified separately for two groups using first a narrow and then a broad approach to define housing stability. (Note that all chronically homeless individuals are included within the group that had any housing needs.)

Chronically Homeless Individuals

This group included only chronically homeless individuals according to the HUD definition of chronic homelessness. The individuals were homeless for at least 12 consecutive months (with at least one of those months in SFY 2012) and/or they were homeless for at least four non-consecutive episodes over a three-year period that totaled 12 or more months (an episode could be a single month).

For this population, an individual was identified as homeless in a month if he/she received emergency shelter or transitional housing in the Homeless Management Information System (HMIS) and/or had a living arrangement recorded in the DSHS Automated Client Eligibility System (ACES) as homeless without housing, emergency housing shelter, or battered spouse shelter.

Individuals with “Any Housing Need”

Individuals in this group were identified as homeless or unstably housed in at least one month in SFY 2012. This group includes those from the group of people who were chronically homeless. Housing instability was measured using a broad indicator that combines data from six different information systems, including HMIS and ACES. For more detail about the data sources for this group, please refer to RDA’s publication, *Identifying Homeless and Unstably Housed DSHS Clients in Multiple Service Systems, State Fiscal Year 2012*.

Measures

Total medical and behavioral health care costs were measured by combining all of the following costs into an overall total used to determine cost deciles:

- All medical and managed care capitation payments
- All Division of Behavioral Health and Recovery mental health service costs, and
- All DBHR-chemical dependency service costs

The chronic illness risk score is based on health service diagnoses and pharmacy claim information.¹ The score is calibrated to equal one (1) for the average person in Washington State enrolled in the Social Security Insurance (SSI) disability program. Therefore, the proportion of clients with a score of one (1) or higher reflects the proportion with expected future medical costs that are as high as or higher than the average SSI recipient.

The presence of substance abuse treatment need and mental illness were identified through diagnoses, prescriptions, health service, and behavioral health treatment records (as well as alcohol/drug-related arrests for substance abuse treatment need).

¹ See Gilmer, T., Chronic, R., Fishman, P., & Ganiats, T. G. (2001). The Medicaid R-x model - Pharmacy-based risk adjustment for public programs, *Medical Care*, 39(11), 1188–1202 and Chronic, R., Gilmer, T., Dreyfus, T., & Lee, L. (2000). Improving health-based payment for Medicaid beneficiaries: CDPS, *Health Care Financing Review*, 21(3), 29–64.

Appendix B: Stakeholder Engagement

The development of this white paper was informed by stakeholder engagement conducted by the Washington Low Income Housing Alliance. The Housing Alliance is a statewide homelessness and affordable housing policy and advocacy organization in Washington State.

Between January 2014 and June 2014, the Housing Alliance reached out to more than 200 stakeholders across Washington State to engage key individuals, organizations, and government entities in the work of creating a Medicaid Supportive Housing Services Benefit. Representatives from following groups of stakeholders were engaged during this period:

Affordable Housing and Homelessness Stakeholders

- Supportive housing service providers and developers
- Homelessness and affordable housing service providers
- Local continuum of care coalitions
- Local and statewide homelessness and human services coalitions and advocates
- Affordable housing and homelessness policy experts

Health Care Stakeholders

- Primary and behavioral health care providers
- Washington's five Medicaid Managed Care Organizations
- Local and statewide health care coalitions and advocates
- Health care policy experts

Government Stakeholders

- Representatives from county and city governments, including individuals from local human services and health departments and housing authorities
- Representatives from state agencies, including the Department of Social and Health Services, the Department of Commerce, and the Health Care Authority
- State-level elected officials and their staff

During this period, the Housing Alliance took the following actions to engage stakeholders:

- Provided background information and briefings regarding the health and housing needs of individuals experiencing chronic homelessness, the Medicaid program, supportive housing and research citing it as an evidence-based practice to address chronic homelessness, and the concept of a Medicaid Supportive Housing Services Benefit. This information was provided in one-on-one, small group, and large group meetings; workshops; conference calls; and presentations.
- Solicited information and feedback about the housing and health care needs of people experiencing chronic homelessness, and the opportunities, challenges, and key considerations related to the development of a Medicaid Supportive Housing Services Benefit in Washington State. Information was collected through one-on-one and small group meetings, interviews, and an online survey.
- Collaborated with key stakeholders to garner feedback about the content of this white paper and to identify next steps to forward the creation of a Medicaid Supportive Housing Services Benefit in Washington State. Feedback was collected in one-on-one and small group meetings.

Appendix C: State Medicaid Policy Activities Related to Supportive Housing

As evidence continues to establish supportive housing as an intervention that stabilizes people with chronic illnesses and/or behavioral health conditions and reduces health system costs, states are exploring ways to better utilize health care financing for the services that supportive housing residents need.

In analyzing current state Medicaid policy, CSH has identified common themes in the alignment of supportive housing services and Medicaid:

- Supportive housing residents who obtain Medicaid eligibility due to mental illness have the most comprehensive Medicaid benefits package compared to other Medicaid recipients. This means Medicaid is most likely to reimburse at least a portion of a supportive housing resident's services.
- Of the long list of services needed by supportive housing residents, Medicaid is least likely to include the following as benefits: pre-tenancy supports (outreach and engagement), tenancy support services (such as crisis intervention and eviction prevention), general case management, and transportation to appointments.
- When reimbursable, supportive housing services are either structured in a fee-for-service payment arrangement or a single case rate that is too low for high-need populations.
- Supportive housing residents with substance use conditions, adults who not have children or those who have not been determined to be disabled under Supplemental Security Income (SSI) regulations (even in states that have expanded Medicaid) often do not have a benefits package that includes any of the services delivered in supportive housing.
- Many supportive housing providers do not have the infrastructure and do not meet the provider qualifications required to receive Medicaid reimbursement.

CSH is working with and tracking state efforts to pursue the changes needed to finance through Medicaid the services that supportive housing residents need to achieve both housing and health stability. These states are exploring a variety of financing mechanism options:

- Health Homes
- Accountable Care Organizations
- 1115 waivers
- Home and Community-Based Services
- Partnerships between managed care entities and supportive housing service providers

Some states are also recognizing a need to invest in rental assistance and capital development to align with potential Medicaid service financing targeted to people with high healthcare needs and costs. The following describes these mechanisms and provides examples of state and local jurisdictions taking advantage of these opportunities.

Health Homes

Health homes are designed to be person-centered systems of care that facilitate access to and coordination of a full array of primary and acute physical health services, behavioral health care, and community-based services and supports. Health homes can improve health care quality and clinical outcomes, as well as the patient care experience, while also reducing per-capita costs through more cost-effective care.

The State Option to Provide Health Homes for Enrollees with Chronic Conditions, section 2703 of the Affordable Care Act, provides enhanced federal funding for states planning to expand or implement a health home initiative that will serve individuals with chronic conditions. States electing this option receive eight quarters of an enhanced Medicaid federal reimbursement for Health Home services provided to chronically ill populations. Some states are using this option to address the needs of homeless or supportive housing beneficiaries.

Washington

In 2013, Washington began implementing its Health Home State Plan Amendment. The State decided to use its Health Home option to target anyone with multiple chronic illnesses. Health home providers include a variety of health entities: hospitals, managed care organizations, mental health clinics, regional support networks, community health centers, etc. Washington promoted supporting beneficiaries experiencing housing instability by giving additional points to applicants for Health Home funding that included housing providers in their networks. The state also lists housing repeatedly as a key service and expects care coordinators working in health homes to link members to housing.

New York

The federal Centers for Medicare and Medicaid Services (CMS) approved New York's Health Home State Plan Amendment more than two years ago. New York's Health Home State Plan Amendment targets beneficiaries with mental health needs, those with chronic physical conditions and those living with HIV/AIDS. A variety of providers (including managed care plans, hospitals, behavioral health providers and community health clinics) lead Health Home networks. These networks are creating multidisciplinary teams made up of medical, mental health, chemical dependency treatment providers, social workers, nurses, and other care providers who are all led by a dedicated care manager who will assure that enrollees receive needed medical, behavioral, and social services in accordance with a single plan of care. New York's health home program requires supportive housing as an element of the health home networks. The state plan amendment did not include detail about the supportive housing model and how the health home model would link to this type of housing. Providers are now developing these relationships and experimenting with the best way to link efforts.

Accountable Care Organizations

An accountable care organization (ACO) is a type of payment and delivery reform model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned patient population. A group of coordinated health care providers form an ACO, which then provides care to a group of patients. The ACO may use a range of payment models (including a capitated per-member, per-month rate or fee-for-service where a Medicaid payment provider is reimbursed for each individual service usually provided in 15 minute increments). The ACO is accountable to the patients and the third-party payer for the quality, appropriateness, and efficiency of the health care provided.

Illinois

In Chicago, Together4Health, a partnership led by Heartland Health Outreach (HHO) has created an ACO model. HHO was selected by the Illinois Medicaid office to manage a coordinated care entity (CCE) that will coordinate care for Medicaid beneficiaries who have chronic health conditions. Together4Health (T4H) was the only CCE selected that includes permanent supportive housing as part of the care model. The T4H partnership encompasses more than 30 primary care physicians, hospitals, dentists, behavioral health professionals and supportive housing programs. The goal of the CCE is to improve how participants experience health care, improve the health of the participants, and reduce the per capita costs of care for the participants. In addition to health care entities, T4H also includes permanent supportive housing stakeholders in the governance structure. Housing case managers and health care coordinators will work together to keep people housed and ensure their health care needs are met. The results should reflect decreased costs to the health care system, and potentially decreased costs of providing some supportive services through the housing partners. Because the services delivered are currently financed through the existing Medicaid system there are no new resources available for reimbursement of services delivered in supportive housing. Supportive housing service providers and the Together4Health network are continuing to discuss ways to change this and improve investment in supportive housing services.

Home and Community Based Services (HCBS) (1915i State Plan Amendment)

The HCBS 1915i State Plan Amendment has population and services parameters that align well with supportive housing residents and their needs. Although eligible populations must meet certain needs-based criteria determined by the state, they do not have to need an institutional level of care—a level that could exclude many people in supportive housing. In addition, services can include case management, in-home assistance with activities of daily living, tenancy support services and other activities that supportive housing residents may need initially and as they age that are not typically Medicaid reimbursable. As states consider ways to improve Medicaid financing of supportive housing services, the 1915i's broad

population target, intention to connect people to community-based housing and services, and lack of a federal cost-neutrality requirement makes this option very attractive.

Louisiana

Louisiana, with assistance from the Technical Assistance Collaborative (TAC), redesigned its delivery and financing of home and community-based services using multiple 1915 waivers and the 1915i state plan amendment. The HCBS services are managed by the behavioral health managed care organization Magellan. The state's goals are to address chronic homelessness, reduce the number of people residing in institutional care (such as nursing homes), and improve the integration of developmental disabilities services, behavioral health, primary care and housing. Louisiana has defined eligible populations as Medicaid beneficiaries who have a significant, long-term disability, who are receiving services from the Department of Health and Hospitals, and who are in need of housing and support services. Magellan manages the supportive housing providers, tracks availability of units, and reimburses supportive housing services providers for case management and other housing-oriented services.

1115 Waivers

1115 Medicaid waivers allow states to experiment with new Medicaid financing and service delivery models. These waiver requests must be cost neutral to the federal government. States must be demonstrating and researching service delivery models and any renewal requests included in a waiver must illustrate that the state is testing something new or different than in the previous waiver. The high level of flexibility of this waiver means that services in supportive housing could be made Medicaid reimbursable in a variety of ways. For example states can target specific populations and ensure they receive services not typically reimbursed by Medicaid, such as tenancy supports through case management. Under a 1115 waiver, states can also alter financing for these services in ways other than what typical federal Medicaid regulations allow. For example, states can alter payment arrangements so that a set of services are billed through bundled or case rate payments rather than a fee-for-service arrangement.

New York

In April 2014, New York received approval of an 1115 waiver request to dramatically change its Medicaid system. Although its \$750 million proposal to reinvest the federal portion of projected cost savings into supportive housing operating and capital costs was denied, the approved waiver does include provisions that improve Medicaid resources for supportive housing services and New York remains committed to finding ways to increase supportive housing capacity using Medicaid financing. Using this waiver, the state will be able save a projected total of \$17.1 billion. The waiver explains the ways the state plans to reinvest the state's portion of those savings, \$8 billion, back into the health care system. The primary use of the savings is to create new payment models that incentivize hospitals, nursing homes, and other health care providers to improve patient outcomes and reduce overutilization of expensive care by using more community-based care options. The plan will promote community-wide collaborations to implement innovative projects focused on delivery system reforms through planning grants, provider incentive payments, administrative costs and workforce programs. This plan is also known as a Delivery System Reform Incentive Payments (DSRIP) program. Several states are using DSRIP programs to alter traditional payment and delivery systems (see Texas below). The main goal of New York's DSRIP program is to reduce avoidable hospital use by 25% over the next five years by establishing 25 projects for which eligible safety-net providers (major public general hospitals, FQHCs, and nursing homes) can apply to implement over five years. Approved providers will receive incentive payments based on their performance and outcome milestones.

Of interest to housing and homeless providers is one specific initiative that directs hospitals to partner with housing providers to develop transitional housing for high risk patients who are unable to safely transition from a hospital when the acute medical needs are fully met. This transitional housing would provide short term care management to allow transition to longer term care management and would allow additional time to support rehabilitation, stabilization, and patient confidence in self-care before returning to permanent housing.

Illinois

Illinois has submitted an 1115 waiver that largely seeks to change its Medicaid management from fee-for-service to a managed care system. This waiver will recognize the need to reduce Medicaid costs through improvements in targeting highly-vulnerable, high cost patients. To this end, one of the 1115 waiver provisions would provide managed care entities with incentive payments based on performance measures. The state is seeking CMS approval to allow managed care organizations to re-invest these incentive payments into supportive housing services, rental assistance, or capital investment. Illinois expects negotiations with CMS to take place in 2014.

Texas

In 2012, CMS approved an 1115 Waiver for Texas which expanded Medicaid managed care statewide. As an element of this waiver, Texas created an \$11.4 billion DSRIP which, combined with required state/local matching funds, would fund enhanced system access and performance in 20 newly-formed Regional Health Plan areas. CSH has worked with two regions of the state, Austin/Travis County and Houston/Harris County, that have directed Medicaid 1115 funds to comprehensive services in supportive housing for Medicaid-enrolled and other low-income populations. The City of Austin will utilize Medicaid 1115 payments to fund comprehensive services for at least 75 individuals experiencing homelessness and mental illness. The City of Houston will provide services for at least 200 individuals who will receive services through partnerships between federally-qualified health clinics and local homeless providers. In both cases, these services will be coupled with housing subsidies provided via other local sources.

Rhode Island

In 2012, Rhode Island proposed an 1115 waiver that continued a Medicaid redesign process the state began in 2008. State health department staff recognized the state is spending high Medicaid resources on beneficiaries experiencing chronic homelessness. Through data analysis, state staff estimated savings of more than \$2 million by investing in supportive housing services. The state's 1115 waiver proposal included a separate benefits package for people experiencing chronic homelessness, which would offer a bundled or case-rate payment to supportive housing service providers who would offer services in housing to these high-acuity beneficiaries. Services included in this case rate payment include: outreach and engagement, tenancy supports, case management, general behavioral health counseling, transportation and general assistance managing chronic conditions. Although most of Rhode Island's 1115 waiver was approved, CMS asked for more time to deliberate on this supportive housing proposal. The state expects a final decision in 2014.

Managed Care

As states seek to reduce health care costs, implement innovative models and improve health outcomes, they are increasingly contracting with managed care organizations (MCOs) to carry out the provisions of their Medicaid programs. Medicaid managed care has been around for a long time; however, populations with multiple barriers to services and complex needs were often "carved out" of the MCOs' responsibilities. In recent years, states have begun to require MCOs to add these populations as members. This has been especially true in states that have expanded Medicaid under the Affordable Care Act.

MCOs are now looking for interventions that help control costs for this population to meet state performance measures within the capitated rate states pay them to deliver and coordinate care. MCOs are using demonstration projects, such as Money Follows the Person or those provided through the federal Center for Medicaid and Medicare Innovation, to experiment with ways to integrate housing and services while gaining assurances that they will see a return on investment for certain members.

Medica - Minnesota

The health plan Medica has subcontracted with Hearth Connection, Inc., a non-profit, intermediary organization that provides administrative support, fiscal oversight and research to a network of supportive housing providers, to conduct a demonstration project targeting Medica's 88 highest cost users of Medicaid. Medica has decided to address the needs of its Medicaid enrollees who are experiencing long-term homelessness and chronic conditions and who are frequent users of health systems. All 88 enrollees were identified through an algorithm Medica created. Once Medica staff identifies potential enrollees for the demonstration, they then provide the names of these enrollees to Hearth Connection. Hearth Connection

locates each enrollee and determines eligibility for its program, including whether the person is homeless. If eligible, Hearth Connection, in its role as intermediary, facilitates payment of services and housing using existing federal Housing and Urban Development resources and the existing state voucher program) and conducts staff training (on issues such as case management and care coordination integration, navigating the health system, and understanding supportive housing), for both Medica and supportive housing providers. Medica pays for services within supportive housing, delivers care coordination, and conducts the evaluation of the project. Foundations and other funders, such as CSH, have funded an evaluation study and assisted Hearth Connection in covering its administrative costs.

Massachusetts Behavioral Health Partnership - Massachusetts

The Massachusetts Behavioral Health Partnership (MBHP), in partnership with Massachusetts Housing and Shelter Alliance (MHSA), developed a behavioral health managed care model that supports members who have experienced chronic homelessness and are now residing in a Housing First program. MBHP's program includes eight strategic partnerships between behavioral health providers in the MBHP network and non-network housing programs that have federal or state funded housing vouchers that could be used for MBHP enrollees. MBHP worked with the state to create a new benefit: the Community Support Program for People Experiencing Chronic Homelessness (CSPECH). MBHP's state contract included the Community Support Program (CSP) as a benefit for its members. MBHP and MHSA used this benefit as a foundation to create CSPECH, and MBHP has seen markedly improved outcomes, including reduced health care costs, improved health outcomes, and housing stability.

Enrollees must meet four criteria to qualify for the benefit: 1) they must be enrollees in the MBHP insurance plan, 2) they must be chronically homeless, 3) they must meet medical necessity criteria for the CSP services, and 4) they must either be receiving intensive outreach for placement into a Housing First model program or living in a Housing First unit. MHSA coordinates the provider participation in the program and ensures that the supportive housing units are meeting with the program requirements. MBHP designed the CSPECH benefit to allow Medicaid to reimburse for the care coordination and case management not included in a basic Medicaid plan, and to pay for these services using a bundled rate. MBHP pays the service providers \$17 per day per person to receive a mix of the services. Bundling the services into a single payment structure streamlines provider administration and reimbursement. The state included the CSP as part of a 1115 waiver.

Community Behavioral Health - Philadelphia

The City of Philadelphia operates a not-for-profit behavioral health managed care organization called Community Behavioral Health (CBH). In recognition of the need for supportive housing investment, CBH partners with the city's housing agency and utilizes both Medicaid and city designated funding to finance services and housing for supportive housing residents. If a participant is deemed eligible, (specifically if they are chronically homeless), CBH offers a set of services that community-based homeless service providers deliver. CBH cost savings become city revenue largely re-invested back into supportive housing in the form of rental assistance and other funds for supportive housing.

State Investments in Housing

Although the top Medicaid priority is financing the services component of supportive housing, states and the health system recognize a need to make more affordable housing units available in order to create enough supportive housing to achieve maximum cost savings. As mentioned above, New York attempted to get federal approval to reinvest its portion of savings achieved through NY's Medicaid Redesign efforts into the rental assistance and capital of housing creation. This proposal was rejected. However, New York is investing state-only resources into operating costs and capital development. The following is a brief explanation of New York's initiative.

New York State

In addition to the health and services components of the Medicaid Redesign Team (MRT) explained above, New York also created a complementary supportive housing Initiative to ensure that housing creation accompany the increased health care services resources. The New York Legislature allocated \$75 million in State Fiscal Year (SFY) 2012–13, \$86 million in SFY 2013–14 and \$95 million in SFY 2014–2015 to fund capital investment, rental subsidies, and service supports. The state targets funding to high-cost, high-need users of Medicaid, and the New York State Department of Health (DOH), Office of

Mental Health (OMH), Office of Alcoholism and Substance Abuse Services (OASAS), and the Office for People with Developmental Disabilities (OPWDD) administer the program and allocate the resources.

The 2013–14 MRT Supportive Housing Initiative also created seven pilot projects to test models of care.

1. Health Homes Pilot Project (DOH): Supports 500 rent and service subsidies for supportive housing providers to house and serve unstably housed high cost Medicaid recipients in scattered-site market-rate rental apartments. Funding would serve persons referred from health homes.
2. Step Down/Crisis Resident Pilot (OMH): Supports capital and operating funding to allow for a specified number of existing community residential service providers to convert a certain number of beds into crisis or step-down service units. The goals are to transition individuals from psychiatric hospitals into community settings and divert individuals in crisis from use of such services
3. Nursing Home to Independent Living (DOH): Supports rent and service subsidies to individuals with mobility impairments or other severe physical disabilities an alternative pathway to community living.
4. OMH Supported Housing Supplement (OMH): Supports rent and service subsidies to supplement supportive housing providers in offering limited service enhancement to Medicaid recipients with serious mental illness and high costs who are enrolled in health homes and living in scattered-site apartments. This project will allow for necessary day-to-day continuity of place-based, wraparound support services through a flexible, critical-time-intervention approach.
5. Homeless Senior Placement (Office for Temporary Disability Assistance - OTDA): Provides rent supplement to older individuals residing in homeless shelters for long periods of time who receive social security income/social security disability income but are not eligible for existing supportive housing programs. It intends to reduce Medicaid spending that is predictive and targets a group of individuals who are likely to become high Medicaid users.
6. Health Home HIV Rental Assistance Pilot (DOH): Supports rental assistance for homeless and unstably housed Health Home participants diagnosed with HIV infection but medically ineligible for the existing HIV-specific enhanced rental assistance program for New Yorkers with AIDS or advanced HIV-illness.
7. Senior Supportive Housing Pilot (DOH): Supports capital and supportive services to enable low-income seniors to remain in the community, including seniors aging in place in supportive housing.

All supportive housing MRT funding will be tracked to assess program effectiveness and Medicaid savings attributed to each initiative. Agencies administering MRT supportive housing initiatives are responsible for working with providers to collect data and submit it into the Medicaid Data Warehouse. The state’s portion of savings generated from these initiatives will be reinvested into this supportive housing initiative.

Conclusion

Although there is still much work to do, these initiatives illustrate that state and local leaders recognize that in order to meet health care outcomes and cost-savings goals, supportive housing must be part of the equation. Medicaid and other health care financing for the services and supports within supportive housing are essential to increasing supportive housing capacity to serve people who need it. To ensure states’ work in this arena is successful, supportive housing providers and stakeholders must be actively engaged from the beginning to ensure the following.

- The benefit package is comprehensive and includes the essential services delivered in supportive housing.
- The Medicaid reimbursement level, especially as states transition from fee-for-service to case rates, is adequate.
- Identified eligible populations, medical necessity and needs criteria are defined accurately.
- Supportive housing providers can become Medicaid billing entities, as appropriate.

CSH is proud to be working with these innovative states and tracking these important initiatives to integrate healthcare and supportive housing. We will be featuring more examples of innovation regularly in “The Pipeline,” our blog at csh.org.