August 30, 2013

Integrating Supportive Housing and Health Care in Washington State

King County
Department of Community and Human Services

COMMITTEE TO END HOMELESSNESS KING COUNTY

CSH
The Source for Housing Solutions

Integrating Supportive Housing and Health Care in King County and Washington State

This paper was commissioned by the King County Department of Community and Human Services on behalf of the Committee to End Homelessness in King County (CEH). Its purpose is to:

1) Offer CEH stakeholders and others an overview of today's evolving health care environment.
2) Share the findings of CSH's Medicaid Crosswalk, which highlights the alignment and gaps between the services provided in supportive housing and those covered in Washington's State Medicaid Plan.
3) Provide an overview of the companion paper to this document, The Business Case for a Medicaid-Financed Supportive Housing Services Benefit in Washington State.
4) Provide CEH stakeholders with an overview of the key opportunities in which to engage in planning efforts related to supportive housing and health care.

Background on Supportive Housing

Supportive housing is an innovative and proven solution to some of our communities' toughest problems. Supportive housing combines affordable housing with services that help people who face the most complex challenges to live with stability, autonomy and dignity. Supportive housing is:

- Recognized by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) as an evidence-based practice for people with behavioral health diagnoses.
- A cost-effective coordinated care model.
- Implemented in many affordable housing settings to meet the housing and services needs of individuals and families with disabilities, both homeless and at-risk of homelessness who need supportive services in order to remain in housing.

Numerous research studies show that supportive housing improves mental health and substance use outcomes, improves overall health, and reduces the recurrence of homelessness. Supportive housing serves people who need services in order to succeed in housing and who need housing in order to succeed in services. Many move into supportive housing from homelessness, have disabilities, or are otherwise highly vulnerable, and a portion of people served is currently Medicaid-eligible. Homeless adults, particularly those who are chronically or long-term homeless are far more likely to suffer from chronic medical conditions, such as HIV/AIDS, hypertension and diabetes and to suffer complications from their illness due to lack of housing stability and regular, uninterrupted treatment.[i] In 2010, an estimated 46 percent of adults in emergency shelters had a chronic substance abuse problem and/or a severe mental illness. For those living in supportive housing, 82 percent had a mental or physical health disability, more than half had a substance abuse and/or serious mental health condition, and 6.4 percent had HIV/AIDS.[ii] Mortality rates among homeless adults are three or more times greater than those of the general population.[iii]

For many individuals with complex chronic health conditions, homelessness or housing instability can be the most significant impediments to health care access, often resulting in excessive utilization 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. Supportive housing is a

critical intervention for addressing the goals of the evolving health care environment while increasing the stability of the most vulnerable people in our community.

1. Overview of the Evolving Health Care Environment

Medicaid

The Medicaid program is the third largest source of health insurance in the United States and one of the largest programs in the federal "safety net" of public assistance. **Medicaid provides essential medical and medically-related services to some of the most vulnerable populations.** Until the Affordable Care Act was enacted, Medicaid served only a portion of people with low-incomes: pregnant women, women with children, and adults with disabilities. The Affordable Care Act gives states the opportunity to expand eligibility to all individuals with incomes below 138 percent of the federal poverty level. States, health care providers, and housing and human service agencies will soon begin work to ensure that these newly eligible individuals are enrolled in insurance as of January 1, 2014. In states that adopt the option for Medicaid expansion, nearly everyone living in supportive housing will be eligible for Medicaid, and most people who are currently homeless will also be eligible. It is imperative that as many people as possible who are living in supportive housing or who are homeless are enrolled in health insurance.

State/Federal Medicaid Relationship

The states and the federal government jointly finance the Medicaid program. Because Medicaid is an entitlement program, the number of people participating in the program and the costs of the services provided to them determines federal spending levels. The relationship between the U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) and each state participating in the Medicaid program is established through a state Medicaid plan and administered by a designated state agency. In Washington, this agency is the Health Care Authority. The state Medicaid plan serves as the contract between a state and CMS. It is a technical document that includes a description of populations eligible for Medicaid, services provided, methods of provider reimbursement, and other program requirements. CMS's approval of the plan authorizes federal financial assistance based on a Federal Medicaid Assistance Percentage (FMAP). This federal matching rate varies from state to state and year to year because it is based on the average per capita income.

Affordable Care Act

The Affordable Care Act (ACA) is about more than expanding health insurance. The Act also addresses fundamental problems with the American health care system. Slowing down the rising cost of health care, which accounted for almost 18% of the Gross Domestic Product (GDP) in 2010, is a key goal of the Affordable Care Act. The Act does not answer all of the questions about needed change or provide one path for improvement. Instead **the ACA allows for innovation on the part of states and providers to experiment with different service delivery and financing strategies that will yield evidence-based models that produce better care, better health outcomes, and reduced costs.** There are distinct changes that the health industry acknowledges will be elements of what comes in the future.

First, we know that there is **a need to move away from fee-for-service payments for health care**. Paying providers for individual visits encourages volume as the driver for raising revenue. It is also difficult to comprehensively serve people with complex health conditions under this payment model. Instead, **we**

need to pay for health outcomes. One way to do this is to package services so they can be paid through a single payment mechanism such as a case rate or a bundled payment. For example, managed care entities are experimenting with developing case rates for high-need individuals. These case rates can encompass basic primary care, behavioral health care and social services. This allows providers flexibility to deliver integrated services.

Second, states want to **improve patient care coordination.** In today's fragmented system, patients must access services from multiple, disconnected providers. One way states seek to better coordinate care is to contract with managed care organizations (MCOs). MCOs track the care that patients receive from multiple health care providers and manage the payments to these providers. This oversight in part, prevents duplication of services. It can also help to ensure that patients receive coordinated care from multiple providers.

States might also choose to establish "health home provider networks" for patients who have high costs. In a health home structure, the state incentivizes a network of health care providers to coordinate their services for patients. Network providers work together to help patients achieve positive health outcomes while keeping costs down. Another form of provider network is an Accountable Care Organization (ACO). These provider networks pull together their existing resources to coordinate care for a specific set of patients. Like a health home structure, the ACO network takes on the financial risk associated with the patient population and receives incentive payments to meet a specific set of metrics, which includes controlling costs.

Finally, the ACA incentivizes **integrated primary and behavioral health care** by reinforcing the mental health and substance use treatment parity legislation of 2008. This legislation and the ACA ensure that access to mental health and substance abuse treatment is comparable to that of treatment for medical issues. This parity is critical because on average, people with severe mental illness die 25 years earlier than the general population.[iv] The ACA incentivizes states and health care providers to adopt the practice of integrating primary care and behavioral health care services to improve health outcomes for people with mental illnesses and those in recovery from addiction disorders.

2. Medicaid and Supportive Housing Services Crosswalk

Today, most supportive housing services funding comes from local and state governments and philanthropy. While flexible and easily accessed by supportive housing providers, these sources are not growing at a rate sufficient to support the quantity of supportive housing units needed to end chronic homelessness. Stakeholders in King County's Committee to End Homelessness wanted to know if federal Medicaid dollars could be brought to the table to increase the effectiveness of these resources and to create a sustainable supportive housing system.

In order for Medicaid to pay for supportive housing services, the **services must be covered within the State Medicaid Plan.** To determine whether the services provided in King County's supportive housing are covered in the State Plan, CSH conducted extensive interviews with DESC and Sound Mental Health staff members covering 80 specific services. CSH also interviewed Plymouth Housing Group and Catholic Housing Services about the services they provide in 12 service categories. All of these services were then cross-referenced with Washington's State Medicaid Plan. Finally, CSH researched Medicaid's current

payment structures to identify the mechanisms through which supportive housing providers can access Medicaid.

This Crosswalk identified a number of areas where supportive housing services currently align with Medicaid requirements. It also identified a number of gaps or challenges that supportive housing providers have in accessing Medicaid. Following is a summary of these areas of alignment and the gaps that need to be addressed in order to more fully utilize Medicaid for supportive housing services.

Alignment between Supportive Housing Services and Medicaid

1. Nearly all of the services provided by King County's nonprofit supportive housing providers are coverable in Washington's State Medicaid Plan under the service modality "Individual Treatment." Examples of the services provided include assessments, service plan development, case management, eviction prevention, independent living skills, motivational interviewing, social health, conflict resolution, money management, and linkages to education, employment and primary care.
2. Supportive housing services are also covered under King County's Regional Support Network (RSN) through its outpatient programs. (The RSN is King County's managed behavioral health care system.)
3. Individuals living in supportive housing who have behavioral health diagnoses and who are enrolled in Medicaid are eligible to receive Medicaid services through the outpatient system.
4. Providers make ongoing efforts to enroll as many residents as possible in Medicaid and to re-enroll those who lose and regain their eligibility status.
5. Three of the five supportive housing providers that receive the largest amounts of capital and operating funding for supportive housing: DESC, Sound Mental Health in partnership with the Low Income Housing Institute, and Catholic Housing Services in partnership with Catholic Community Services, are licensed to provide mental health and chemical dependency services.

Nearly all of the services provided in King County's supportive housing are coverable within Washington's State Medicaid Plan.

Gaps between Supportive Housing Services and Medicaid

1. A handful of services provided in supportive housing are not coverable by Medicaid such as outreach, engagement, enrollment, and some transportation costs.
2. Some services in the State Plan are covered only when conducted face-to-face and are not covered when they are performed on the client's behalf when the client is not present.
3. Medicaid eligibility requires a disability determination. Not all residents of supportive housing qualify, including those with chemical dependency as their primary diagnosis and those with mental health or chronic conditions that do not reach the level that make a person eligible for Social Security or Social Security Disability Income. (Fortunately, this gap can be addressed through Medicaid Expansion and enrollment efforts.)
4. Medicaid enrollment is connected to Social Security enrollment, which can make the process cumbersome, especially for people who are medically fragile, homeless, and/or who have a mental illnesses or chemical dependency. (Sound Mental Health estimates that at any given time only 30%

of the tenants in its supportive housing programs are eligible, enrolled, and participating in services.)

5. Medicaid does not pay for the services provided for the many individuals living in supportive housing who have chronic health conditions who do not have a behavioral health diagnosis.
6. Two of the five supportive housing providers that receive the largest amounts of capital and operating funding for supportive housing: Plymouth Housing Group and Compass Housing Alliance are not licensed to provide mental health and chemical dependency services. Agencies that are not licensed through the RSN or as a chemical dependency provider do not have a mechanism through which to receive Medicaid funds for the coverable services they provide.
7. For providers licensed to provide mental health services, the outpatient case rate is not enough to cover the cost of providing comprehensive services to residents who have high service needs.
8. The provision of mental health and chemical dependency services within supportive housing is bifurcated by separate licensing, provider credentialing requirements, and funding mechanisms (case rate and fee-for-service respectively).
9. All providers feel strongly about the importance of integrated primary and behavioral health care, but they do not have access to funding that pays for integrated care teams.

ANALYSIS

Supportive housing addresses a wide array of tenants' needs and positively impacts health care costs, but little of the services provided in King County's supportive housing are currently covered by Medicaid. Services that are coverable are not reimbursed at the level needed, and they are available only to a limited number of the people who live in supportive housing. Supportive housing providers and funders have created a variety of structures to attempt to provide integrated care with a myriad of mainstream and flexible funding streams. Providers know their work has a positive impact on health care costs, and they are eager to find ways to use dedicated mainstream funding to ensure they can continue to provide these services. Fortunately, evidence is available to demonstrate that supportive housing can save states money, and a number of initiatives are gaining momentum in Washington State as a result of health reform that hold promise for supportive housing.

3. The Business Case for Supportive Housing

CSH's companion paper to this document, The Business Case for a Medicaid-Financed Supportive Housing Services Benefit in Washington State, makes a case that **creating a Supportive Housing Services Benefit** for the 383 individuals in King County between the ages of 18 and 64 who are homeless and who use have average monthly Medicaid expenditures of $3,704 **could result in $1.28 million in net annual State Medicaid savings**. This business case and the significant national and local research that demonstrates improved health outcomes and cost savings created by supportive housing offer a powerful tool for influencing the way Medicaid pays for supportive housing services.

4. Stakeholder Opportunities in Washington State

Given the health needs of today's Medicaid-eligible population and the anticipated health needs of the homeless subset of the Medicaid expansion population, states and managed care organizations have a compelling opportunity to invest in supportive housing services as a well-targeted intervention that will divert the need for more expensive utilization down the road. A number of states across the country have begun examining their state Medicaid plans and potential waivers that may provide opportunities to create a specific Supportive Housing Services Benefit to produce better care, better health outcomes, and reduced costs for people who are homeless. In addition, states are starting demonstration projects specifically designed to address the needs of people with high Medicaid costs. This environment of innovation offers an opportunity to ensure that supportive housing is intentionally incorporated into these efforts. Stakeholders in the Committee to End Homelessness in King County should engage in opportunities to insert the role of supportive housing in the following activities currently underway Washington State.

1. **Medicaid enrollment:** First and foremost, everyone that is living in supportive housing and everyone who is currently homeless should be assisted in enrolling in Medicaid if they are eligible. In addition to ensuring that these individuals and families have coverage, this will ensure that licensed providers who provide coverable services are paid by Medicaid. All providers need to engage in efforts to help residents enroll, and stay enrolled, in Medicaid. This is a first step in better connecting supportive housing with the health care system.

2. **Washington State/King County "Duals Demonstration Project" for dually-eligible (Medicaid & Medicare) individuals:** This demonstration project offers the first opportunity in King County to educate MCOs about the impact of supportive housing and to work with them to create a benefit for people who need supportive housing. A dialogue has already begun with some of the selected organizations, and it is clear that additional technical assistance will help these organizations understand supportive housing and create a Supportive Housing Services Benefit.

3. **Health Homes for people with chronic conditions:** While King County will not implement the federally-assisted Health Homes strategy until after the completion of the three-year duals demonstration project noted above, the County intends to explore the creation of health-home-like structures. Bundled rates, integrated care, and a Supportive Housing Services Benefit can all be created without the additional federal funding available through the national demonstration program because these changes have their own inherent incentives for implementation.

4. **Washington's State Innovation Model (SIM) Grant:** The State's SIM grant application to CMS will lay out a framework for a more integrated health care strategy for Washington. If the plan is accepted by CMS, it will lead to opportunities and funding for significant state-wide transformation. CEH stakeholders should engage in this work and promote the creation of a Supportive Housing Services Benefit as part of the State's transformation.

5. **State Bills 5732 and 1519:** These two State bills address reform of the adult behavioral health system and the creation of uniform outcomes for State contracts, including Medicaid Managed Care, Area Agencies on Aging, RSNs, and County Substance Abuse Programs. The taskforces and directives under these bills provide CEH with important opportunities to demonstrate the

effectiveness of local investments in supportive housing and make the case for funding more fully-integrated services in supportive housing.

6. **King County's Health and Human Services Transformation Plan:** This large-scale local effort to improve health and human services offers important opportunities to ensure that supportive housing services can be more efficiently packaged and funded at both the individual and community level. The plan's emphasis on people with high needs and high health care costs complement the efforts to promote supportive housing as a solution for King County's efforts to address the needs of its most vulnerable citizens.

ABOUT CSH

CSH is working to solve some of the most complex and costly social problems our country faces--like those related to homelessness. All of CSH's housing solutions integrate supportive housing. Supportive housing is a proven intervention that uses housing as a platform for services that create opportunities for recovery, personal growth and life-long success. For more information about the content of this paper, please contact Debbie Thiele: debbie.thiele@csh.org or Peggy Bailey: peggy.bailey@csh.org.

[i] L. Sadowski, R. Kee, T. VanderWeele, and D. Buchanan. "Effect of a Housing and Case Management Program on Emergency Department Visits and Hospitalizations among Chronically Ill Homeless Adults." Journal of the American Medical Association, May 6, 2009, pp. 1771-1778.
[ii] The 2010 Annual Homeless Assessment Report to Congress, op cit.
[iii] M. Larimer, D. Malone, M. Garner, et al. "Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problems." Journal of the American Medical Association, April 1, 2009, pp. 1349-1357.
[iv] National Association of State Mental Health Program Directors (NASMHPD) "Morbidity and Mortality in People with Serious Mental Illness"