

INTRODUCTION

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 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 provider qualifications 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, and
- 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 (ACA), 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 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 their Health Home State Plan Amendment. The State decided to use their Health Home option to target anyone with multiple chronic illnesses. Health home providers include a variety of health entities: hospitals, managed care, 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. Washington 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, 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 (SPA) did not include detail on 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 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 provided usually 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 Accountable Care Organization 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 over 30 primary care physicians, hospitals, dentists, behavioral health professionals and supportive housing programs. The goal of the coordinated care entity 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 to ensure that 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. Since 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 (1915i State Plan Amendment)

The HCBS State Plan Amendment (1915i) has population and services parameters that align well with supportive housing residents and their needs. While eligible populations must meet certain needs-based criteria determined by the state, they do not have to need an institutional level of care, which 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 their 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 homeless, 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; states can target specific populations and ensure they receive services not typically reimbursed by Medicaid, such as tenancy supports through case management. Under an 1115 waiver, states can also alter financing for these services in ways other than 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 their Medicaid system. While their \$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 to 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 create new payment models that incentivize hospitals, nursing homes and others to improve patient outcomes and reduce over-utilization 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 a DSRIP program to alter traditional payment and delivery systems (see Texas below). In New York, the main goal of their DSRIP program is to reduce avoidable hospital use by 25% over the next 5 years by establishing 25 different projects for which eligible safety net providers (major public general hospitals, FQHCs, 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-management before returning to permanent housing.

Illinois

Illinois will soon be submitting an 1115 waiver that largely seeks to change their 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 reinvest these incentive payments into supportive housing services, rental assistance or capital investment. Illinois expects negotiations with CMS to begin mid-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 Delivery System Reform Incentive Pool/Payment (DSRIP) which, combined with required state/local match, would fund enhanced system access and performance in 20 newly-formed Regional Health Plan areas. CSH has worked with two regions, Austin/Travis County and Houston/Harris County, that have directed Medicaid 1115 funds to provide comprehensive services in supportive housing to both Medicaid-enrolled and indigent 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, RI proposed an 1115 waiver that continued a Medicaid redesign process they 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 over \$2 million by investing in services in supportive housing. 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. While most of RI's 1115 waiver was approved, CMS asked for more time to deliberate on this supportive housing proposal. RI expects a final decision in the summer of 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, hard to serve populations with complex needs were often 'carved' out of the managed care entities responsibilities. In recent years, states have begun to require managed care entities 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 their 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 the enrollee and determines eligibility for their program, including whether the person is homeless. If eligible, Hearth Connection, in their role as intermediary, facilitates payment of services and housing (using existing HUD 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, like CSH, have funded an evaluation study and assisted Hearth Connection in covering their 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 their 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 three criteria to qualify for the benefit: 1) they must be enrollees in the MBHP insurance plan; and 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 Community Support Program as part of an 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 the 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

While the top Medicaid priority is financing the services component of supportive housing, states and the health system realize that there is 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 their portion of savings achieved through NY's Medicaid Redesign efforts into the rental assistance and capital of housing creation. This proposal was rejected. But NY is investing state-only resources into operating costs and capital development. The following is a brief explanation of NY's initiative.

New York State

In addition to the health and services components of Medicaid Redesign Team explained above, New York also created a complimentary supportive housing Initiative to ensure housing creation to accompany the increased health care services resources. The NY Legislature allocated \$75 million in 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 NYS 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 to offer limited service enhancement to high-cost Medicaid recipients with serious mental illness enrolled in Health Homes and living in scattered-site apartments. It 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 SSI/SSD 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: 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 into the Medicaid Data Warehouse. The state's portion of savings generated from these initiatives will be reinvested into this supportive housing initiative.

CONCLUSION

While there is still much work to do, these initiatives illustrate that state and local leaders recognize, in order to meet health care outcome 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 increase supportive housing capacity to serve all those who need it. However, to ensure these state experiments are successful, supportive housing providers and stakeholders must be actively engaged from the beginning to ensure that:

- 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, and
- 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