

Public Housing Agencies and Medicaid Managed Care Organizations: Common Goals, Challenges, & Opportunities Serving Vulnerable People



Housing is a Social Determinant of Health (SDOH), and today, many Americans who have low incomes are served by or need the services of both Public Housing Agencies (PHAs) and Managed Care Organizations (MCOs) that manage Medicaid programs. These two entities have more in common than they generally realize—both are motivated to ensure better housing stability and health outcomes, and both are accountable for ensuring quality and managing risk under strict federal requirements.

This guide introduces PHAs and MCOs to each other in order to illustrate common goals and challenges and to highlight emerging opportunities for collaboration. We hope it sets the stage for PHAs and MCOs to learn more about one another and take the first steps in partnering.

Why PHAs and MCOs?

PHAs and Medicaid MCOs generally serve the same people, often the poorest people in a community with a variety of challenges. Links between healthcare delivery and housing instability put a spotlight on the need for stronger relationships between major entities like PHAs and MCOs. Health care and housing providers often serve the same geographic areas because both are regionally, county or city-based. Additionally, both entities use income as a basis for eligibility. PHA income targeting requires at least 40% of families admitted into PHA programs to have incomes below 30% of Area Median Income (AMI).¹ In most cases, closer to 90% of people served by PHAs have incomes below 30% of AMI. MCOs that serve individuals and families receiving Medicaid (public health insurance) also serve people with low incomes. For states that have expanded Medicaid, this includes everyone with incomes below 138% of the federal poverty level (FPL).² States that have not expanded Medicaid serve people with incomes below 100% FPL who also have a qualifying disability or state-specified need for health care. The dollar amounts for incomes at 30% AMI and 138% of FPL are often relatively similar in most areas.

¹24 CFR 903.2 <https://www.law.cornell.edu/cfr/text/24/903.2>

² <https://www.healthcare.gov/glossary/federal-poverty-level-FPL/>

What are Public Housing Agencies?

PHAs administer rental assistance and rental housing allocated by the U.S. Congress and administered by the federal Department of Housing and Urban Development (HUD). PHA's are responsible for the management and oversight of physical public housing sites as well as the provision of Housing Choice Vouchers (formerly referred to as Section 8).

Public Housing is safe, decent and affordable housing for families, people with disabilities, and the elderly with low incomes. The physical development of public housing appears in all shapes and sizes ranging from a single family home to high-rise apartments. What is common in all models is that the property is owned and operated by the PHA, and each tenant pays not more than 30% of their income for rent and utilities or a flat rent that provides affordability for people with extremely low incomes. According to HUD, there are an estimated 1.2 million households living in public housing.³ PHAs administer public housing under an Admission and Continued Occupancy Policy (ACOP) plan.

Housing Choice Vouchers provide rental assistance to low income individuals and families, people with disabilities, and the elderly. When an individual receives a voucher, they rent an apartment in the private rental market and pay their landlord 30% of their income toward rent and utilities. The PHA then pays the landlord the difference between the tenant's payment and the total cost of the rent up to an amount the PHA determines to be a "reasonable rent." PHAs administer HCVs under a HUD-approved Administrative Plan.



The ACOP and PHA Administrative Plan govern who will be served and how the programs are managed relating to waitlist, subsidy payments, preferences, and eligibility criteria. PHAs are required to comply with fair housing rules and do not discriminate on the basis of federally protected classes. PHAs have only three legislatively-mandated exclusions: persons who are registered on a lifetime sex offender registry, persons who have been convicted of manufacturing methamphetamine in public housing, and persons who owe a PHA money.⁴ Any additional exclusions for criminal justice involvement or other issues are locally determined by the PHA and included in its ACOP and/or Administrative Plan. PHAs may also choose to set local "preferences" which indicate who moves to the top of their waitlists for assistance. PHAs are required to make their policies and preferences available for public comment before adopting them and submitting them to HUD each year.

³ https://www.hud.gov/topics/rental_assistance/phprog

⁴ <https://www.hud.gov/sites/documents/2012-28ATTACHMENT.PDF>

How are PHA's funded?

Congress appropriates funding for housing choice vouchers (HCVs) and public housing programs and sets the statutes that authorize PHAs to receive federal funding. HUD then organizes and administers implementing regulations for PHAs. Public housing programs are funded by the federal government through the Public Housing Operating Fund and the Public Housing Capital Fund. The Public Housing Operating Fund is designed to make up the difference between what public housing tenants pay and the actual cost of operating the public housing development. The Public Housing Capital Fund pays for brick and mortar upkeep of the development such as renovations and equipment replacements. For the past ten years, public housing operating and capital funds have been appropriated at levels far below what HUD has determined to be necessary for the sustainability of public housing buildings.

For more information on PHAs and how to align their programs with services, please visit [CSH's PHA Toolkit](#).

What are Managed Care Organizations?

MCOs are a key player in most state's health care delivery systems. States work with MCOs in order to efficiently deliver healthcare services to Medicaid beneficiaries and manage costs. States can apply to the federal government for a Medicaid waiver to use managed care through the Centers for Medicare and Medicaid Services (CMS).⁵ States can then choose to procure the services of a managed care entity to manage Medicaid on their behalf. States must contract with more than one managed care organization, and they can contract with MCOs on a statewide, regional or county basis. The MCO creates a network of providers that delivers healthcare services. These networks may include hospitals, health systems, clinics, individual providers, and in some cases, supportive housing service providers. The MCO is responsible for managing the delivery and cost of care. MCOs are generally held accountable by a system of outcome measures called Healthcare Effectiveness Data Information Set or HEIDS measures.⁶ MCOs can be for-profit, not-for-profit, local, or national entities. Many large MCOs also manage private health insurance plans.

MCOs have a variety of internal departments to achieve their mission of better health for the communities they serve. Executive leadership manages the state contract, outside relationships and sets the priorities for the organization. Network development teams manage the provider network and ensure an adequate number of health care providers offering quality services. Clinical management teams manage the individual care that each member receives. Member services works directly with health plan members to educate, engage and support them to improve their health.



How are MCOs funded?

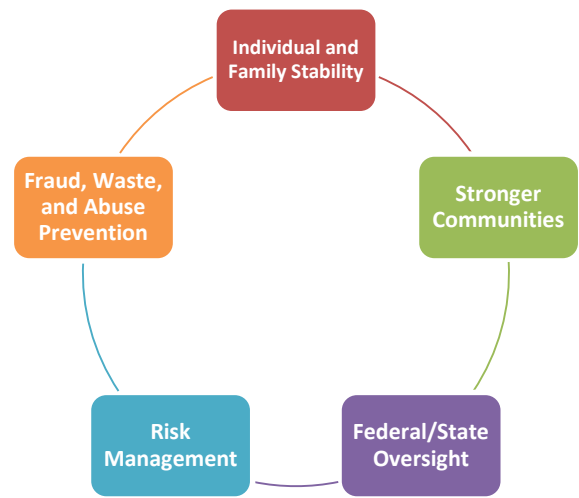
MCOs receive state and federal Medicaid funding through their contracts with states. When MCOs contract to manage Medicaid for a state, they negotiate per-member-per-month rates for services.

⁵ <http://www.csh.org/wp-content/uploads/2017/01/Quick-Guide-to-Medicaid-Waivers-and-State-Plan-Amendments.pdf>

⁶ <http://www.ncqa.org/hedis-quality-measurement/hedis-measures/hedis-2017>

What do PHAs and MCOs have in common?

PHAs and MCOs have a lot in common in terms of day to day operations. Both types of organizations operate under federal oversight, which contributes to a shared value in preventing fraud and managing risk with each transaction between the organization and its clients. Ultimately, both organizations share the goals of increasing stability for vulnerable individuals and families and building stronger communities. Following are five key commonalities between MCOs and PHAs.



- I. Increasing Individual and Family Stability:** PHAs and Medicaid MCOs have a common goal to serve people well. Their core missions are the bedrock of housing and healthcare support for people with low incomes. PHAs provide housing and rental subsidies and MCOs coordinate the provision of healthcare services. And both organizations often go above-and-beyond these requirements to help link the people they serve to other organizations that can support them. PHAs wants their tenants to remain stably housed for as long as possible. Many of their tenants who are elderly and/or who have disabilities can become at risk of losing their housing if they do not have access to the healthcare and housing stability services that they need. MCOs also want their members to remain stably housed because people have a much greater ability to access preventative and ongoing healthcare services when they are stably housed. Safe and affordable housing is a social determinant of health.
- II. Building Stronger Communities:** PHAs and MCOs know that serving individuals well means ensuring that they live in healthy communities. PHAs are often the owners and operators of entire housing communities. The healthcare system is increasingly moving toward models of accountable communities of health that focus on regional healthcare delivery and public health efforts. CMS, the federal department responsible for the Medicaid and Medicare Programs, supports these partnerships through the Accountable Health Communities (AHC) program.⁷
- III. Federal and State Oversight:** Both PHAs and MCOs follow federal regulations. In the case of MCOs, these regulations, along with additional requirements imposed by the state, are part of their state contracts. For PHAs, these regulations and payment agreements are held directly with HUD.
- IV. Managing Financial Risk:** PHAs and MCOs understand and manage a great deal of financial risk. MCOs are accountable for meeting the health care needs of a designated population with a fixed amount of funding. If health care costs increase and/or individuals' health declines, the MCO can lose money. If they help people stay well, the MCO can make a small profit (limited by regulations). Similarly, PHAs are required to serve a certain number of households in the housing choice voucher program with a fixed amount of funding. If they serve larger households or rents go up, their costs go up. In the voucher program, PHAs must carefully estimate how many people can be "shopping" for a rental unit at any given time to ensure they are fully leased without going over their allocation of funds.

⁷ <https://innovation.cms.gov/initiatives/ahcm>

V. Preventing fraud, waste, and abuse: While fraud is relatively uncommon, the risk of fraud in the management of public resources is of significant to both PHAs and MCOs. This concern weighs heavily on the risk management in both types of organizations, and a fine balance has to be applied to preventing and investigating fraud while ensuring programs don't become bogged down with too much administrative burden. As organizations that are ultimately accountable to taxpayers, both MCOs and PHAs must balance achieving mission with public sector accountability to their government funders and their ultimate funder, the taxpayer.

What are the benefits of PHA and MCOs working together?

PHAs and MCOs want to see the people they serve access resources and attain stability as effectively as possible. This common ground is where PHAs and MCOs can begin to partner and align their delivery of housing and healthcare.

- PHAs that know their local MCO can help their residents get connected to healthcare services to help their tenants remain healthy and living in independent housing longer. This is a benefit to MCOs that can reduce the census and costs of providing nursing home and other long term care institutional care by instead providing home and community based services.
- MCOs can support their members in applying for public housing or housing choice vouchers when they better understand the system and have relationships with their local PHAs. Stably housed members will have fewer missed appointments, better care coordination, and stronger patient engagement than those experiencing homelessness and housing instability.
- MCOs can cross reference their member data with public housing building addresses and/or local zip codes. If there are geographic areas of a community where MCOs and PHAs are serving a high concentration of the same clients, they can coordinate resident-based health education classes and engagement activities for the community.
- PHAs and MCOs can explore co-location of services, educational campaigns for members around a particular health issues, and alignment of healthcare and housing services.
- MCOs and PHAs both have resources that can create supportive housing. Providing housing subsidies, medical care, and tenancy supports can significantly reduce unnecessary institutionalization and homelessness.

Getting Started!

CSH recommends three approaches to MCO/PHA connections.

1. *Pick up the phone and give your local PHA or MCO a call!* It's that easy. Many states will post a MCO directory to their state healthcare agency website. A quick search will connect you the MCO in your community. PHAs often operate or maintain their own websites equipped with contact information. PHAs are both city and county-based, operating separately. This guide can also be a great resource to provide a starting point in the conversation. If you need assistance in making these connections, your local CSH office can facilitate these types of discussions.
2. *Host a regional or statewide convening about PHAs and MCOs.* Some states have already hosted statewide convening building relationships by sharing common ground and common goals will facilitate a more coordinated effort to serve clients and increase access to health care resource.

For example, in North Carolina, PHAs and MCOs are laying the groundwork for more collaborative efforts through a statewide convening, targeting housing and health care leaders in a diverse range of geographic areas. This statewide gathering will help these once siloed industries to expand their understanding of patient and client needs.

3. *Attend each other's industry group meetings, events, and conferences.*

- If you are hoping to learn more about PHAs, check out the Council of Large Public Housing Agencies ([CLPHA](#)). CLPHA is a national non-profit working to preserve and improve public and affordable housing through policy advocacy and multi-system collaboration. Here you will find information about upcoming conferences and ideas for coordination with other systems in your area. CLPHA is prioritizing a variety of cross sector partnerships between sectors such as health care and education that impact their residents.
- The health care sector hosts a wide variety of events that support their industry. The National Academy of State Health Policy ([NASHP](#)) is very influential and the National Association of Medicaid Directors ([NAMD](#)) is another event to connect with health care industry staff.
- You can identify the MCO in your area by visiting your State's Department of Health and Human Services website. Each state is required to have a Medicaid Advisory Committee that is open to the public and is another way to network with health care industry leaders.
- As SDOH is more commonly accepted as a priority area for health care, community leaders are reaching out to serve on boards from related sectors that serve the same populations.
- Many states have health information exchanges to help share data between health care partners.⁸ Engage local groups and see what data sharing possibilities exist in your community.



CSH connects MCOS and PHAs at the local level to create supportive housing and stop the cycle of homelessness and unnecessary institutionalization. If you know of a PHA or MCO interested in learning more about supportive housing, CSH can deliver technical assistance and training to help with next steps. We provide translation services to start the conversation between health and housing systems and the examples and technical expertise needed to form cross-sector partnerships. Please visit us at csh.org or contact us at consulting@csh.org to learn more. This publication was created with significant support from Vanessa Kopp a former CSH intern who currently serves as the Coordinated Entry System Manager at the Raleigh/Wake Partnership to End and Prevent Homelessness.

We are grateful to our partners at [Capital One](#) for their generous support, which ensured the resources necessary for us to research and publish this paper.

⁸ <https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html>