

FINANCING OPPORTUNITIES  
AND CHALLENGES:  
USING MEDICAID FOR SERVICES IN  
SUPPORTIVE HOUSING

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# We know what is needed

- Housing is a social determinant of health
- Rx= make housing available as quickly as possible
  - ▣ Offer people with complex health and social problems the support they need to get and keep housing
  - ▣ Multi-disciplinary services for health, behavioral health, and support for housing stability
  - ▣ Frequent, face to face contact to engage people, build trust and motivate change
- Focus the most expensive housing and services on people who really need these interventions
  - ▣ Use data and assessment tools to prioritize based on vulnerability and/or cost and potential for savings



## Growing number of older homeless adults

More than 30% of individuals in homeless shelters nationwide in 2013 over age 50  
32% increase in number of homeless persons between 51-61 between 2007 and 2013

# Housing First + Supports = a better use of health care resources

## Savings

- Fewer hospitalizations, emergency room visits, stays in detox, residential treatment, or nursing homes
- Savings in other systems – ambulance, shelters and jails

## Better care and outcomes

- People are more likely to get recommended care if they are in housing
- Substance use declines even if not a condition of housing
- Reduced mortality



How can we pay for the care homeless patients need?

How can Medicaid and other resources in health care system pay for effective care – including the SUPPORT that helps people get and keep housing?

# Medicaid's role in supportive housing for chronically homeless people

HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE)

- Medicaid and Permanent Supportive Housing for Chronically Homeless Individuals: Emerging Practices from the Field (2014)
- A Primer on Using Medicaid for People Experiencing Chronic Homelessness and Tenants in Permanent Supportive Housing (2014)
- Literature Synthesis and Environmental Scan (2011)
- Four papers published by HHS/ASPE in 2012

# Major changes in financing for services

- Expansion of Medicaid eligibility – in some states - to include nearly all homeless people
- States make policy decisions about Medicaid benefit design and implementation
- Increasing role of Medicaid managed care
- Changes in health care finance and delivery systems
  - ▣ impacts for both chronically homeless people and health care providers who serve them

# Medicaid and solutions to homelessness

- Medicaid is a partnership between state and federal government with shared costs
  - ▣ States make choices about benefit design, optional benefits and waiver requests
- Medicaid services can help people get and keep housing
- Some Medicaid services can be provided in supportive housing (on-site in housing, home visits)
- Other Medicaid services in the community can help meet the needs of people who are homeless or supportive housing tenants



# Medicaid managed care

- Enrollment in Medicaid managed care is rising
  - ▣ People newly eligible for Medicaid
  - ▣ Seniors and people with disabilities (SSI)
  - ▣ Needs and risks for groups newly enrolled in health plans are very different from children and their parents
- Plan and provider selection
  - ▣ Many homeless people are auto-assigned if they do not choose a plan and provider
  - ▣ Big implications for clinics and health care providers that serve homeless people – and for partnerships to link services to housing

# A mix of payment mechanisms for service providers

- Fee for service
  - ▣ Usually for encounters or minutes of service
  - ▣ Sometimes for a bundle of services (per episode, day, or month)
- Shifting “from paying for volume to paying for value”
- Capitation
  - ▣ Per member per month payment for a defined set of services
  - ▣ Sometimes with financial incentives for controlling utilization & costs (shared risk / savings) and quality
- Grants and contracts for programs
  - ▣ May pay for costs not covered by Medicaid reimbursement

# Medicaid for services in supportive housing – current practices

- Most often Medicaid is covering mental health services connected to supportive housing
  - ▣ To be eligible, a person must have a serious mental illness
- Some Federally Qualified Health Centers (FQHC) also provide services in supportive housing
  - ▣ Payment for visits with doctors (including psychiatrist), mid-level practitioners (NP, PA), LCSW
- Integrated primary care and behavioral health services
  - ▣ Often partnerships use both Medicaid payment models
- Funding from federal, state, county, local sources is needed to cover what Medicaid doesn't pay for

# FQHC services linked to housing

- Satellite clinics in supportive housing buildings
- Clinic located close to supportive / affordable housing
- Home visits to people living in scattered site housing
- Collaborations with mental health service providers to create interdisciplinary teams linked to housing
- Health Care for the Homeless programs can continue to serve homeless people after they move into supportive housing

# Challenges and gaps

- Costs for some members of inter-disciplinary teams are not reimbursed in FQHC rates set under federal and state policies
  - ▣ Nurses do not provide billable encounters
  - ▣ Some case management costs may not be included in rates
- Productivity concerns
  - ▣ Fewer visits per day when working outside of clinics
- States may limit reimbursement for same-day visits
- Managed care:
  - ▣ Difficult to get reimbursed if people enrolled in and assigned to other primary care providers
  - ▣ PMPM rates not adjusted to reflect acuity / complexity of needs
  - ▣ Provider networks may not facilitate continuity of care
- Some FQHCs have not adapted service delivery approach to meet needs of people experiencing chronic homelessness
  - ▣ May have limited capacity for serving people with serious mental health or substance use disorders

# Financing for mental health services

- Optional Medicaid benefits can cover mental health services
  - Rehabilitative services
  - Targeted case management
  - Home and community-based services
- Eligibility often limited to people with serious mental illness
- Services can be delivered in a range of community settings
- With supervision by clinicians, services can be delivered by teams with peers, workers with other skills and training
- Effective service strategies support recovery by doing “whatever it takes”
  - Flexible funding from grants, states, or local government pays for services not covered by Medicaid

# Community Support Teams and ACT covered by Medicaid in some states

- Teams are mobile and interdisciplinary
  - ▣ Assertive engagement, individualized and flexible approach
  - ▣ Frequent home visits, face-to-face contact in range of settings
  - ▣ Small caseloads
- For persons with serious mental illness who meet additional criteria:
  - ▣ Recent and/or multiple hospitalizations, ED visits, contacts with law enforcement
  - ▣ Inability to participate or remain engaged in less intensive services; inability to sustain involvement in needed services
  - ▣ Inability to meet basic survival needs, homeless
  - ▣ Co-occurring mental illness and substance use disorder
  - ▣ Lack of support systems

# Challenges and gaps

- Fragmented and inconsistent approaches to covering services for medical, mental health, and substance use disorders
  - ▣ In most states Medicaid benefits cover limited array of services to address substance use – only in approved settings, making it hard to deliver integrated services for co-occurring disorders
- Covered mental health services and goals usually must be related to diagnosis, symptoms and impairments related to mental illness – not (directly) related to substance use problems or other health needs
- Provider requirements often not designed for mobile, team-based models of service or shared electronic records
- These are state policy decisions – not federal requirements



# Challenges and gaps (continued)

- Federal rules make distinction between “rehabilitative” and “habilitative” services
  - ▣ Some skills people need to get and keep housing may not be covered
- As people recover, they may lose eligibility for ongoing support from intensive mental health service models
  - ▣ Other less intensive services may not be mobile with capacity to do “whatever it takes”
  - ▣ It can be hard to return to more intensive services during a crisis that could lead to losing housing
  - ▣ Responsibility for mental health services may shift to managed care plans
  - ▣ Changes may disrupt trusting relationships

# What's working?

- Outreach teams assess homeless people who are not engaged in the mental health system and can determine eligibility for services
- States and counties understand mobile, team models and provide training for Medicaid reimbursement with focus on services in supportive housing and other settings outside of clinics
- Partnerships use flexible funding to create integrated teams linking behavioral health and primary care services
- Mental health providers help consumers navigate managed care enrollment, provider selection, access to care
- Medicaid managed care plans contract with behavioral health providers for risk assessment and care management

# Medicaid for services in supportive housing

## – collaborations with hospitals and health plans

- Capitation creates incentives for hospitals and health plans to coordinate care and pay for services that reduce avoidable costs
  - ▣ But uncertainty about how spending for new types of services will be reflected in future rate-setting
- Medicaid managed care plans in some states are paying for services in supportive housing for their members
  - ▣ Trusted service providers do face to face health risk assessments and care coordination
  - ▣ Diversionary services to reduce avoidable hospitalizations by providing community support
  - ▣ Case management services linked to housing assistance
  - ▣ Medical respite / recuperative care and intensive case management for frequent users

# Some counties with public hospitals are investing in supportive housing as health care

- Housing for most vulnerable and high cost homeless people reduces avoidable hospital costs and improves health
  - Evidence of savings justifies health system investment
- Hennepin Health funds housing navigators
  - ▣ Facilitate housing referrals for patients with high costs and/or health conditions impacted by homelessness
- Los Angeles DHS Housing for Health program
  - ▣ County health department pays nonprofit partners for case management and housing-related services
    - Linked to housing developed with city funding and vouchers administered by housing authorities
    - Public-private partnership funds Flexible Housing Subsidy Pool
    - Permanent and interim / respite housing options

# Medicaid for services in supportive housing – more options for state policy

- Home and community-based services (HCBS) for people with disabilities
  - ▣ Medicaid can pay for housing locators and other housing-related services and supports
- Health homes – an optional Medicaid benefit
  - ▣ For people with multiple chronic health conditions and/or serious mental illness
  - ▣ Whole-person, comprehensive and individualized case management
  - ▣ More than a medical home

# What changes are needed to finance what works?

- Payment mechanisms and rules create incentives (and remove obstacles) for teams that integrate care for health, mental health and substance use needs
- Medicaid coverage for services in settings outside treatment programs to address harmful substance use, and motivate people to make changes to reduce risks
- Payments to health plans and providers are adjusted to reflect risk and complexity of consumer needs
  - ▣ Taking social determinants of health into consideration
  - ▣ Allowing reinvestment of savings to pay for services that help reduce avoidable costs
- For vulnerable people with complex needs, services to support housing stability are recognized as essential part of health care and care coordination
  - ▣ Cost are incorporated into rate-setting
  - ▣ Savings are shared



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