Report to the Social Services Appropriations Subcommittee

Leveraging Medicaid Dollars for Homeless Services

Prepared by the Division of Medicaid and Health Financing, Utah Department of Health in Collaboration with Housing and Community Development, Department of Workforce Services

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UTAH DEPARTMENT OF HEALTH

WORKFORCE SERVICES
HOUSING & COMMUNITY DEVELOPMENT

During the 2018 legislative session, Representative Ray requested the Utah Department of Health (UDOH), together with the Department of Workforce Services (DWS), conduct further research and report to the Social Services Appropriations Subcommittee on the costs and benefits of leveraging Medicaid dollars for homeless services. This report is submitted in response to that request.

Background

Homelessness is a multifaceted issue. Contributing factors can be personal, societal and cultural and include such things as job loss, domestic violence, divorce, lack of affordable housing, physical or cognitive disability, mental illness, and substance use disorder. Individuals experiencing homelessness encounter a variety of health and social challenges, including acute and chronic medical and behavioral health conditions, criminal justice system involvement and extended periods of unemployment. Individuals with significant chronic medical and behavioral health conditions often lack health insurance, or have limited access to health care. These challenges can pose significant barriers to maintaining stable housing.

The U.S. Department of Housing and Urban Development (HUD) defines someone as chronically homeless if he or she is homeless now, has one or more disabling conditions and has been homeless continuously for a year or more or has had four or more homeless episodes in the previous three years totaling one year.

The United States Interagency Council on Homelessness notes, *"People experiencing chronic homelessness cost the public between $30,000 and $50,000 per person per year through their repeated use of emergency rooms, hospitals, jails, psychiatric centers, detox and other crisis services."*[1] Many individuals experiencing homelessness use emergency department and inpatient hospitalization as their primary form of medical care.

The scope of homelessness is difficult to measure. To attempt to measure this population, community leaders must rely on a variety of fluid data sources to inform them about trends, demographics, and outcomes. The Utah Homeless Management Information System (UHMIS) is a data collection system that is designed to record and store information about individuals who experience homelessness. It should be noted that not all service providers enter information into the UHMIS due to privacy laws or because they are not receiving funding that requires them to participate.

In calendar year 2017, 4,299 individuals were identified in the UHMIS as experiencing chronic homelessness.

[1] . *"People Experiencing Chronic Homelessness."* 15 April 2016. United States Interagency Council on Homelessness. http://usich.gov/population/chronic

The State of Utah, Annual Report on Homelessness 2018[2], characterizes progressive steps Utah policymakers have taken to address homelessness issues including information about Operation Rio Grande which launched August 14, 2017. Operation Rio Grande included a three-phase plan to restore public safety in the Rio Grande District of Salt Lake City. The three-phase plan includes:

PHASE 1: PUBLIC SAFETY AND RESTORING ORDER is measured by comparing part one offenses (serious or frequent crimes) to a three-year average. By June 2018, part one crimes in the Rio Grande area were down 43 percent compared to the three-year average.

PHASE 2: ASSESSMENT AND TREATMENT supports people struggling with mental illness and drug addiction so they can return to a path of self-reliance. From August 2017 to June 2018:

- 243 treatment beds have been added
- 192 behavioral health assessments have been completed to determine appropriate referral for those interested in ORG drug court
- 105 individuals have pled into the Drug Court program
- 66 sober living residential beds have been added
- 92 individuals were placed in sober living

PHASE 3: DIGNITY OF WORK prepares and connects individuals to income that supports housing. From November 2017 to June 2018:

- 92 individuals became employed
- 309 job seekers developed an employment plan

In November 2017, in association with Operation Rio Grande and House Bill 437 (2016 legislative session,) the UDOH obtained approval from the Centers for Medicare and Medicaid services (CMS), through an 1115 Demonstration Waiver, to enroll a new population of individuals experiencing chronic homelessness into the Utah Medicaid program. A component of the newly authorized Medicaid coverage group known as the Targeted Adult Medicaid (TAM) includes individuals experiencing homelessness. Since obtaining CMS approval, Utah Medicaid has enrolled approximately 1,800 individuals identified as chronically homeless.

In addition to providing general health care coverage to the new TAM population, Utah Medicaid received CMS approval to cover short-term, residential treatment services for substance use disorder in facilities with 16 or more beds. The State was encouraged by CMS approval of these services, since CMS had previously been unwilling to approve such a service. Since coverage began, more than 500 Medicaid members identified as experiencing homelessness have benefited from this service. Currently, no additional homelessness-specific Medicaid-funded services are provided to this population.

[2] *State of Utah, Annual Report on Homelessness 2018, https://jobs.utah.gov/housing/scso/documents/homelessness2018.pdf*

While federal law prohibits Medicaid from paying for housing itself (room and board), in recent years, CMS has offered additional guidance to states regarding opportunities to use Medicaid funding to provide supportive services to individuals experiencing homelessness. There are examples across the nation where states utilize Medicaid funding to support individuals experiencing homelessness. Key services covered in these models are the *"supportive"* services associated with Permanent Supportive Housing as one example.

Permanent Supportive Housing and Related Services

Permanent Supportive Housing (PSH) Defined

The US Health and Human Services *Primer on Using Medicaid for People Experiencing Chronic Homelessness* describes Permanent Supportive Housing as,

> *"PSH is intended to provide affordable housing combined with supportive services for people with disabilities or other significant barriers to housing stability. PSH is decent, safe, affordable, community-based housing, providing tenants with the rights of tenancy through leases and similar arrangements. PSH staff help tenants link to voluntary and flexible supports and services…*[3]"

PSH is intended to help individuals:

- Manage chronic medical conditions and prevent avoidable health crises
- Improve health and wellness through regular preventive and primary care
- Understand and manage the symptoms of mental illness and develop coping skills
- Restore and strengthen interpersonal, functional, and community living skills that are impaired
- Motivate changes in risky behaviors and harmful substance use, engage people in treatment for substance use disorders, and support recovery
- Identify risk factors for relapse and develop relapse prevention plans and strategies
- Get and keep housing by providing help to find and apply for housing, build skills to negotiate with landlords and get along with neighbors, and problem solve to support stable living in the community
- Reduce frequent and avoidable hospitalizations, emergency room visits, stays in detox programs, nursing homes, or other crisis or institutional care.

The PSH philosophy of "housing first" versus that of "treatment first"

"Treatment First" - Early models of PSH required individuals with behavioral health conditions (mental health or substance use disorders) to be in treatment prior to being eligible for PSH. This model resulted in a series of hurdles that an individual had to overcome to be eligible for housing. With the many challenges experienced by this population, this model has had limited success.

[3] US Health and Human Services *Primer on Using Medicaid for People Experiencing Chronic Homelessness* https://aspe.hhs.gov/system/files/pdf/77121/PSHprimer.pdf

"Housing First" - is an evidenced-based PSH model that prioritizes housing above meeting specific residency requirements, such as substance use disorder or mental health treatment mandates. Housing First takes the approach that an individual can achieve stability in permanent housing directly from homelessness and that stable housing is the foundation for pursuing other health and social services goals.

In order for Housing First to be effective, individuals must be empowered with choices in housing selection and service participation. When an individual is able to exercise that choice, he or she is more likely to be successful in maintaining housing and making life improvements. The National Alliance to End Homelessness stated:

> *Housing First does not require people experiencing homelessness to address all of their problems including behavioral health problems, or to graduate through a series of services programs before they can access housing. Housing First does not mandate participation in services either before obtaining housing or in order to retain housing. The Housing First approach views housing as the foundation for life improvement and enables access to permanent housing without prerequisites or conditions beyond those of a typical renter. Supportive services are offered to support people with housing stability and individual well-being, but participation is not required as services have been found to be more effective when a person chooses to engage ("Housing First Fact Sheet").*[4]

Models for delivering PSH

The United State Interagency Council on Homelessness describes:

> *"There is no single model for supportive housing's design. Supportive housing may involve the renovation or construction of new housing, set-asides of apartments within privately-owned buildings, or leasing of individual apartments dispersed throughout an area. There are three approaches to operating and providing supportive housing:*

- ***Purpose-built or single-site housing:*** *Apartment buildings designed to primarily serve tenants who are formerly homeless or who have service needs, with the support services typically available on site.*
- ***Scattered-site housing:*** *People who are no longer experiencing homelessness lease apartments in private market or general affordable housing apartment buildings using rental subsidies. They can receive services from staff who can visit them in their homes as well as provide services in other settings.*

[4] "Housing First Fact Sheet.". National Alliance to End Homelessness. http://endhomelessness.org/wp-content/uploads/2016/04/housing-first-fact-sheet.pdf

- ***Unit set-asides:*** *Affordable housing owners agree to lease a designated number or set of apartments to tenants who have exited homelessness or who have service needs, and partner with supportive services providers to offer assistance to tenants."*[5]

Efficacy of PSH

PSH models show strong evidence regarding helping individuals who experience chronic homelessness to achieve housing stability and reduce inappropriate use of health-related services. An excerpt from the National Academies of Sciences, Permanent Supportive Housing: *Evaluating the Evidence for Improving Health Outcomes Among People Experiencing Chronic Homelessness*[6] describes:

> *"Another health care utilization study conducted in Seattle by Mackelprang and colleagues (2014) examined emergency medical services (EMS) utilization before and after entering a single-site Housing First program. The 91 program participants had severe alcohol problems. The study did not monitor health outcomes, but examined and categorized the reasons for EMS calls through examination of administrative data, both for 2 years prior to enrollment in PSH and 2 years following enrollment in PSH. The variables of interest were trauma/injury, substance use, psychiatric difficulties, medical illness, and other. The study found a 54 percent reduction in EMS calls for those who entered supportive housing."*
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> AND
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> *"A pilot study conducted in Portland, Oregon, examined the effects of single-site supportive housing on health care costs, health care utilization, and health outcomes for 98 "highly medically vulnerable" individuals experiencing homelessness (Wright et al., 2016, p. 21). This study, using retrospective survey responses and Medicaid administrative claims data, showed that placing individuals experiencing homelessness and high medical costs into supportive housing significantly reduced Medicaid expenditures for inpatient hospital and emergency department services for physical health issues, with an average annual reduction of $8,724 in the year after moving in (Syrop, 2016). The self-reported data also showed a reduction in hospital stays and emergency department visits, indicating a shift toward using primary care services rather than acute care services. Although these results are promising, the absence of a comparison group and the use of retrospective self-reported data limit interpretations of this study."*

Although PSH research has demonstrated effectiveness in achieving housing stability and reducing inappropriate use of health related-services, there is limited availability of research

[5] https://www.usich.gov/solutions/housing/supportive-housing/

[6] National Academies of Sciences, Engineering, and Medicine. 2018. *Permanent Supportive Housing: Evaluating the Evidence for Improving Health Outcomes Among People Experiencing Chronic Homelessness.* Washington, DC: The National Academies Press. doi: https://doi.org/10.17226/25133.

to demonstrate cost-effectiveness or improved health outcomes associated with the model. The National Academies of Sciences publication further stated:

> *Unfortunately, the literature on cost-effectiveness of PSH is sparse; few randomized controlled studies have been conducted. Most studies in this regard use a quasi-experimental design. Further, the available studies have not been conducted in a manner that is methodologically aligned with generally accepted health care cost-effectiveness research design. In principle, the most robust scientific evidence to answer the question would come from studies using a randomized design and that cover a comprehensive array of cost and effectiveness measures. Ideally, such studies would allow for constructing the cost-effectiveness ratio to compute the net cost required per unit of quality-adjusted life-years or, at a minimum, provide information on the net cost required for increasing one stably housed day. Unfortunately, there were very few randomized studies and among these, cost measures were incomplete and effectiveness measures scarce.*

However, the publication also noted:

> *"Leveraging Medicaid may make it possible to bring PSH to greater scale, and to reach homeless and at-risk persons with housing before chronic homelessness takes a greater toll on their health outcomes and the overuse of public services."*

Medicaid Funding of Homeless Services

For this report, the agencies have primarily focused on PSH as a model for consideration. However, it is important to note that Medicaid funding is not contingent upon use of a PSH model. Medicaid funding is currently authorized to provide a variety of similar supports to those eligible for behavioral health services. To increase the availability of services to a broader population of individuals identified as experiencing homelessness (whether they have a co-occurring behavioral health condition or not), Medicaid funding could be leveraged to support other discrete services such as case management, peer support services, conducting outreach, assessment and referral, and providing supported employment or non-medical transportation services.

Medicaid Authorities and Supportive Services Coverage Options

To cover supportive homeless services, the UDOH would need to seek authorization through a Medicaid waiver authority or State Plan Amendment.

Waiver Authority

1115 Demonstration Waivers - Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that are found by the Secretary to be likely to assist in promoting the objectives of the Medicaid program. The purpose of these demonstrations, which give states additional flexibility to design and improve their programs, is to demonstrate and evaluate state-specific policy approaches to better serving Medicaid populations.

In 2016, Washington received CMS approval to implement an 1115 waiver to address the impact on health outcomes related to lack of stable housing and employment through supportive housing services and supported employment services.

State Plan Amendment

Section 1915(i) State Plan Amendment - Section 1915(i) of the Social Security Act gives states the option to offer a variety of home and community based services (HCBS) under the Medicaid State Plan rather than through an HCBS waiver program. Through this authority, states can:

- Target the HCBS benefit to a specific population, such as individuals experiencing chronic homelessness. Individuals served are not required to meet an institutional level of care
- Define the services included in the benefit, including state-defined and CMS-approved "other services" applicable to the population

Under this authority, states must provide services to all eligible Medicaid members who meet the target criteria, and cannot limit the number of people served.

In a 2016 report titled, *Use of 1915(i) Medicaid Plan Option for Individuals with Mental Health and Substance Use Disorder*, the U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation reported seven states had approved 1915(i) programs for individuals with mental illness/substance use disorder.[7] In addition, Nevada is currently proposing a 1915(i) program targeting support services for individuals experiencing homelessness.

Program Planning and Implementation

To implement a program through either waiver or State Plan authority, UDOH in collaboration with DWS and DHS, would work with stakeholders and the public to make decisions about a variety of operational details. Implementation items would include things such as, defining program eligibility requirements, covered services and detailed service definitions, and establishing payment rates and provider qualification requirements. Homeless service providers that meet the established provider qualifications and are not currently enrolled to provide Medicaid services would need to be enrolled as Medicaid providers. Most of the homeless service providers are not Medicaid providers and would need to enroll. Other decisions such as if the services will be delivered on a fee-for-service basis or through managed care contracts would also need to be made.

Potential Service Utilization and Cost Estimates

Examples of Supportive Services Offered through PSH

[7] https://aspe.hhs.gov/basic-report/use-1915i-medicaid-plan-option-individuals-mental-health-and-substance-use-disorders

Depending on the populations served at a particular site or through a particular program, examples of supportive services offered as a component of PSH, that could be eligible for Medicaid funding, include:

- Case Management
- Tenancy Support Services
- Behavioral Health Services (mental health and substance use disorder services)
- Assistance with Chronic Disease Management
- Work Exploration/Supported Employment Services
- Life Skills Training
- Non-medical Transportation
- Personal Care Services

For purposes of this report, the UDOH did not estimate the cost of a wide array of services, but focused on a few core services. Case management and tenancy support services are expected to be utilized more frequently in the first three months of PSH. The projected first year cost for these supportive housing services is estimated to be $6,750 per member. In addition, Medicaid may be able to provide one-time transition support payments to assist an individual in purchasing housing necessities. These one-time transition services are estimated to cost $1,500 per member. Work exploration and supported employment services is estimated to be utilized by half of the chronically homeless population if covered as a Medicaid benefit. The estimated annual cost for these services is $3,900 per PSH member accounting for members that may not utilize the service. The total first year cost of PSH would be $12,150 per member. Each of these services will receive Federal Financial Participation (FFP) at a rate that is dependent on the member's eligibility category. If PSH benefits are provided to the newly eligible Medicaid Expansion population effective April 1, 2019, Utah would need to seek CMS approval in order to receive the enhanced 90% FFP. Without this approval, FFP would be expected at the traditional Federal Medical Assistance Percentage (FMAP) rate of approximately 70%. The total Medicaid recipients of PSH services may be anywhere between the 1,800 TAM enrollees experiencing chronic homelessness and the 4,300 adults identified by UHMIS.

These cost projections assume a fee-for-service payment for each discrete service, but there are other methodologies that could be considered such as development of a daily rate or covering the services within a managed care environment.

Utah currently has a variety of PSH sites in operation with capacity to serve approximately 2,940 individuals. In calendar year 2017, UHMIS shows that approximately 2,400 individuals received PSH.

In Utah, some Medicaid funding is currently in use for PSH provided to individuals with housing instability who have co-occurring behavioral health conditions. These models typically include a single-site environment in which case managers, clinical behavioral staff, and other support staff are available on site 24/7. Under this model, payment rates for

services can vary widely based on the complexity of the population served and the array of services available. These models are typically pay for services through a daily rate.

Current Barriers to Funding PSH - Inadequate and Unreliable Funding Streams

One of the most significant barriers to systemic implementation of PSH is inadequate and unreliable funding streams. The National Academies of Sciences publication describes:[8]

> *The fragmented nature of the funding for PSH is magnified by the fact that the amount of available funding is generally inadequate to meet the demand and need. Except for Medicaid, these funding sources are discretionary appropriations of the federal budget or the budgets of states and local governments and are therefore subject to strict budget constraints (such as sequestration) and significant fluctuations from year to year. As a result, many of the programs allocate funds through highly competitive application processes, making it difficult to plan through reliance on specific sources. Funding allocations, when awarded, often fall short of the true cost of delivering services, especially in light of the acute needs of clients and the complexity of service delivery.*

Conclusions

As noted previously, national data suggests that people experiencing chronic homelessness cost the public between $30,000 and $50,000 per person per year based on repeated use of high cost services. In addition, the National Academies of Sciences' report on PSH states the following regarding the benefits of PSH:

> *"consistent with the results of randomized trials, observational studies of retention of persons experiencing homelessness in supportive housing showed that most programs had high annual retention rates, indicating that PSH is able to keep persons who have formerly experienced homelessness off the streets for significant periods of time."*

Leveraging Medicaid funding to provide homeless services could result in efficiencies and cost savings to homelessness service delivery sectors. Medical costs for Medicaid-covered members may be reduced under a stable housing model, however the UDOH would need more experience in order to quantify the medical cost savings in relation to the cost of providing additional homelessness-related services.

[8] National Academies of Sciences, Engineering, and Medicine. 2018. *Permanent Supportive Housing: Evaluating the Evidence for Improving Health Outcomes Among People Experiencing Chronic Homelessness.* Washington, DC: The National Academies Press. doi: https://doi.org/10.17226/25133.