MEDICAID STRATEGIES: SERVING PEOPLE EXPERIENCING HOMELESSNESS & SUPPORTIVE HOUSING TENANTS

Carol Wilkins
We know what is needed

- Housing is a social determinant of health
  - Health care providers should screen for homelessness as a “vital sign”
  - Housing stability improves health outcomes and reduces avoidable costs
- Rx= make housing available as quickly as possible
  - Offer people the support they need to get and keep housing
  - Frequent, face to face contact to engage people, build trust and motivate change
  - Multi-disciplinary services for health, behavioral health, and support for housing stability for people with complex health and social problems
- 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
How can we pay for the services homeless people 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 and solutions to homelessness

- Medicaid is a partnership between state and federal government with shared costs
  - Understand the choices your state has made about coverage expansion, 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 or homeless assistance programs
  - Funding from HUD or other homeless programs often pays for some services that could be covered by Medicaid
  - Service providers may be able to access Medicaid reimbursement
- Partnerships: Medicaid services can help meet the needs of people who are homeless or living in supportive housing
Necessary for Medicaid financing

- Covered service
  - Using an authority established by federal law
  - Most services delivered outside of hospitals and doctors offices are “optional” benefits established by agreement between state and CMS (State Plan or waiver)

- Eligible person
  - Enrolled in Medicaid - and
  - Medical necessity for these services

- Qualified provider and setting in which service are delivered
  - State establishes qualifications and procedures
  - Managed care plans may be selective and have additional requirements
Major changes in financing for services

- Expansion of Medicaid eligibility – in some states - to include nearly all homeless people
- States continue to 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’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
Medicaid authorities sometimes used to cover services linked to housing

- Rehabilitative Services
- Targeted Case Management
- Federally Qualified Health Centers (FQHC)
- Home and Community Based Services
  - 1915(c) Waiver services for people eligible for nursing home level of care
  - 1915(i) State Plan
- Health Home Services
- Medicaid Waivers
  - 1115
  - 1915(b)
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

Potential for coordination – and fragmentation
- Plans have responsibility for coordinating care for members
- Multiple plans manage health benefits for residents in many communities
- Medical care, mental health, substance use, dental, and long term care services may be covered through separate plans or “carve out” systems

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 Medicaid services to housing
Developing a crosswalk to identify Medicaid financing opportunities

- **Step 1: start with the services**
  - What services are provided in supportive housing and other homeless assistance programs?
    - What additional services may be needed to house the most vulnerable and chronically homeless people?
  - Does Medicaid pay for similar services for some people in your state? If yes …
    - Are any providers using Medicaid now to pay for these services in supportive housing or other homeless assistance programs?
    - Can these services be delivered in a person’s home or other community setting — or only in a clinic or certified facility?
    - Who manages the availability of these services - through a managed care plan, “carve out”, or other arrangement?
    - For whom are these Medicaid services covered?
Developing a crosswalk to identify Medicaid financing opportunities (cont.)

- **Step 2: take a closer look at the people**
  - Has your state expanded Medicaid eligibility?
  - Which people are eligible to receive the Medicaid services you have identified?
    - What diagnoses and/or additional criteria are associated with eligibility for these services?
    - What is the process for determining a person’s eligibility for these services (e.g. assessment, service plan development)?
  - Who are the people you are serving or want to serve?
    - Are they enrolled in Medicaid?
    - Are they enrolled in Medicaid managed care plans? Which plan(s)?
    - What services do they want, and how are their needs changing?
    - How many people have serious mental illness?
    - How many are older adults and/or persons with disabilities that interfere with Activities of Daily Living (ADLs)? Are they eligible for nursing home level of care?
Emerging needs: Services for 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
Provider considerations

- Talk to Medicaid providers already engaged in serving homeless people and supportive housing tenants
  - Which Medicaid services are they delivering — and where can those services be delivered?
  - What have they learned about using Medicaid financing?
  - How is Medicaid financing changing, and what are implications for providers?

- What would it take for current service providers of services for homeless people to become qualified providers of some Medicaid services?
  - Direct service staff skills and credentials
  - Supervision and quality assurance
  - Facility requirements
  - Record-keeping and billing requirements
  - Certification and contracting
Medicaid for services linked to supportive housing – current practices

- Most often Medicaid is covering mental health services that can be mobile and connected to supportive housing / rent subsidies
  - To be eligible, a person must have a serious mental illness
- Some Federally Qualified Health Centers (FQHC) also provide services in homeless shelters and supportive housing
  - Medicaid payments 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
Evolving mix of payment mechanisms for service providers

- States and health plans are shifting from paying for volume to paying from value
- **Fee for service**
  - Usually for encounters or minutes of service
  - Sometimes for a bundle of services (episode, day, or month)
- **Capitation**
  - Per member per month payment for defined set of services
  - Some flexibility for health plans and delivery systems to pay for interventions to improve quality
  - Sometimes with financial incentives for controlling utilization & costs (shared risk / savings) and meeting quality goals
- **Grants and contracts for programs**
  - May pay for costs not covered by Medicaid reimbursement
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 improve quality and reduce avoidable costs
- Medicaid managed care plans in some states are paying for services in partnership with CoCs and supportive housing
  - Care coordination delivered face to face by trusted service providers who can find and engage homeless members
  - Diversionary services to reduce avoidable hospitalizations by providing community support
  - Case management services linked to housing assistance
- Some hospitals paying for medical respite / recuperative care and intensive case management for frequent users
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 rehabilitative services – but could be covered as Home and Community Based Services (HCBS)
- As people recover, they may lose eligibility for ongoing support from service models that offer home visits with small caseloads
  - 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
  - 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 settings outside of clinics.
- Partnerships use flexible funding to create integrated teams linking behavioral health and primary care services and leverage reimbursement for covered services.
- Mental health and homeless service 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.
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
Advocacy for changes 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
Contact

carol.wilkins.ca@gmail.com