SUPPORTIVE HOUSING
EVIDENCE-BASED PRACTICE
FINANCING & IMPLEMENTATION

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National perspective

- The evidence guiding policy at national level
- Federal policy encouraging Medicaid financing for services in supportive housing
- Current trends and promising practices
- Emerging strategies to deliver integrated care linked to housing
- Opportunities with managed care and Medicaid waivers

Public policy recognizes supportive housing as Evidence-Based Practice

- Bi-partisan support for increasing supply of permanent supportive housing as the solution to chronic homelessness
- SAMHSA Permanent Supportive Housing EBP KIT published 2010
- *Opening Doors* Federal Strategic Plan to Prevent and End Homelessness
  - Expand the supply of permanent supportive housing
  - Prioritize access for most vulnerable and chronically homeless
  - More coordinated and sustainable funding for supportive services – using Medicaid and other sources
- HUD Homeless Assistance grant program has prioritized investments in supportive housing
  - 96,000 beds of permanent supportive housing added nationwide between 2007-2013
- Supportive Housing also key strategy for achieving *Olmstead* goals of community integration and choice

The case for investments in permanent supportive housing

- Dramatic reductions in costs for hospitalizations, emergency room visits, crisis services, shelter, jail, detox
- High rates of housing stability for people with long histories of homelessness and co-occurring mental health and substance use disorders
- Reduced mortality
- Housing responds to the needs and preferences of consumers
- Housing offers hope and a foundation for recovery – even when sobriety or participation in treatment is not required

NY/NY supportive housing for persons with serious mental illness

- First large-scale evaluation of supportive housing
- Data on 4,679 people placed in supportive housing in New York City between 1989 and 1997 were merged with data on the utilization of public shelters, public and private hospitals, and correctional facilities.
- A series of matched controls who were homeless but not placed in housing were similarly tracked.
- Persons placed in supportive housing experience marked reductions in shelter use, hospitalizations, length of stay per hospitalization, and time incarcerated.
- Before placement, homeless people with severe mental illness used about $40,449 per person per year in services (1999 dollars).
- Placement in supportive housing was associated with a reduction in services use of $16,282 per housing unit per year. Annual unit costs estimated at $17,277, for a net cost of $995 per unit per year over the first two years.

1811 Eastlake in Seattle

- Housing First for homeless adults with substance use disorders, high users of hospital and emergency health services including sobering centers
- Costs for health care and other services:
  - $4066/ person/month one year before entering supportive housing
  - $1492 after 6 months
  - $958 after 12 months
  - Total costs reduced by $4 million for 95 people housed
- Savings far exceeded cost of housing

Chicago Housing & Health Partnership

- Housing and case management for homeless hospital patients with chronic medical conditions
- Rigorous study design (RCT)
  - 29% fewer hospitalizations & hospital days
  - 24% fewer emergency room visits
  - 45% fewer days in nursing homes
- Better health outcomes
  - Higher levels of survival with intact immunity for HIV-positive patients (55% compared to 34% usual care)

The costs of providing housing and case management are more than offset by the reduced costs of hospital, nursing home services, prison or jail, and other social services.

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

Implications from data and research findings

- Many people with behavioral health disorders who experience homelessness have complex, co-occurring health conditions
- Rates of chronic health conditions and potential for extended stays in nursing homes increasing with age
- Big impact on health and savings in costs of medical care when homeless people with behavioral health disorders are housed
- Effective strategies require integration of primary care, behavioral health, and supports for community living

Medicaid and permanent supportive housing

- HHS Assistant Secretary for Planning and Evaluation (ASPE)
  - Literature synthesis and environmental scan 2011
  - Four papers published in 2012 – available at ASPE.hhs.gov
  - Case study in 6 states (report coming soon)
  - Primer – A Guide to Using Medicaid (coming soon)

- Centers for Medicare and Medicaid Services (CMS)
  - State Medicaid Director letter (coming soon)

Medicaid financing for supportive housing services – the big picture

- Medicaid pays for health and behavioral health **services** that help people with disabilities get and keep housing– not housing costs
- Growing number of states seeking flexibility to invest in supportive housing as part of Medicaid waiver proposals and innovative financing mechanisms
- Rapid increases in the number of homeless people and supportive housing tenants who are enrolled in Medicaid managed care

The services in supportive housing

- Flexible and individualized, *"whatever it takes"*
- **Not** a condition of getting or keeping housing
- Help people with disabilities
  - Get and keep housing
  - Restore and strengthen interpersonal, functional and community living skills
  - Understand and manage symptoms of mental illness and develop coping skills
  - Motivate changes in risky behaviors and harmful substance use, and support recovery
  - Manage chronic medical conditions and prevent avoidable health crises
  - Make appropriate use of primary and preventive health care and other community resources

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 at least two different Medicaid payment models
- Funding from federal, state, county, local sources to cover what Medicaid doesn’t pay for

Community Support Teams and ACT covered by Medicaid in IL, DC, LA*

- 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
- Teams are mobile and interdisciplinary
  - Assertive engagement, individualized and flexible approach
  - Frequent home visits, face-to-face contact in range of settings
  - Small caseloads

* LA = Louisiana

FQHC services linked to supportive housing

- Collaborations with mental health service providers to create interdisciplinary teams linked to housing resources
- Satellite clinics in supportive housing buildings
- Clinic located close to supportive housing
- Home visits to people living in scattered site supportive housing
- Challenges: managed care plan enrollment and provider selection / assignment can disrupt these connections

Challenges and gaps

- People with other behavioral health disorders (e.g. substance use and mild to moderate mental health disorders) and/or cognitive impairments need similar services but usually do not meet medical necessity criteria for the mental health services delivered in supportive housing
  - In most states Medicaid covers limited array of services to address substance use – only in approved settings
- Mental health services definitions often do not facilitate integrated attention to co-occurring substance use problems or medical needs
- Service definitions and requirements often not designed for mobile, team-based models of service
- These are state policy decisions – not federal requirements

Challenges and gaps (continued)

As people recover, they may not be eligible for ongoing support from intensive mental health service models

- Other less intensive services may not be mobile with capacity to do "whatever it takes" to support continued stability
- It can be hard to return to more intensive services during a crisis that could lead to losing housing
- Responsibility for some services may shift between mental health system and managed care plans
- Changes may disrupt trusting relationships

What's working?

- Mental Health departments allow outreach teams to assess homeless people who are not engaged in the mental health system and determine eligibility for services
- Training for Medicaid reimbursement includes focus on services in supportive housing and other settings outside of clinics
- Mental health providers help consumers navigate managed care enrollment, provider selection, access to care
- County / state staff involved with providers and billing understand mobile, team models and help reduce obstacles
- Medicaid managed care plans contract with behavioral health providers for risk assessment and care management

Emerging opportunities with Medicaid managed care plans

- Medicaid managed care plans in some states are paying for services in supportive housing
  - Care coordination delivered face to face by trusted service providers
  - Diversionary services to reduce avoidable hospitalizations by providing community support
  - Case management services linked to housing assistance for homeless plan members
- Monthly rates for some covered mental health / behavioral health services

Massachusetts Behavioral Health Partnership (MBHP)

- Medicaid waiver allows Medicaid managed care plan for behavioral health services to pay for community-based “diversionary services” as alternative to hospitalization
- Community Support Program for People Experiencing Chronic Homelessness (CSPECH)
  - Covers mobile, multi-disciplinary services linked to “low threshold” housing
  - For chronically homeless people with mental health and/or substance use disorders
  - Payment on a daily rate throughout time of enrollment

Oregon’s Medicaid waiver

- Care Coordination Organizations (CCOs) are required to consider alternative, “flexible services”
  - Health-related services to improve care delivery and enrollee health
  - To replace or supplant the need for other Medicaid services covered in the state plan

Illinois Medicaid waiver proposal

- Seeking spending flexibility with federal matching dollars for spending not currently matchable under Medicaid to support linkages between health care delivery systems and services that directly impact key social determinants of health, including housing.
- An incentive-based bonus pool to provide incentives for health plans (and other organizations / provider networks) that are at risk financially to invest in housing and housing supports.
  - Payments tied to demonstrating housing stability for members with serious mental illness and/or substance use disorders

A recovery-oriented model must consider the healthcare value of providing supportive housing and employment …for low-income adults with complex health and behavioral health needs.

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

- Home and community-based services for people with disabilities
- 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

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