

Health Policy Brief

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Medicaid and Permanent Supportive Housing. Medicaid offers opportunities to address supportive housing needs, but challenges remain.

WHAT'S THE ISSUE?

The Affordable Care Act (ACA) gave states the option of expanding Medicaid coverage to include childless adults with incomes at or below 138 percent of the federal poverty level beginning in 2014. The ACA also gave states additional tools to use in serving this newly insured population, which would include virtually all of a state's homeless adults. Housing is one of the social and economic factors that play a critical role in determining an individual's health. Improving access to housing and the services needed to maintain housing can be a key component of improving health status for Medicaid beneficiaries. States can also use the new opportunities and tools provided by the ACA and other policy options to support individuals with disabilities living in community settings, including those who had formerly been homeless and other newly eligible members of the expansion population.

WHAT'S THE BACKGROUND?

The [Department of Housing and Urban Development](#) estimates that on a single night in January 2015, roughly 565,000 people were homeless, of whom 37 percent were families with children and 63 percent were individuals. Homeless individuals are more likely than families to be living unsheltered and to experience chronic homelessness. Prior to the expansion of Medicaid coverage under the ACA,

most chronically homeless individuals did not have health insurance, in part because most state Medicaid programs did not cover adults without children.

Housing status and a person's health are interconnected. The [Institute of Medicine](#) noted that health problems can cause homelessness and that homelessness can cause health problems or complicate treatment of existing problems. Individuals who experience chronic homelessness have high rates of substance abuse and mental health disorders and are more likely to suffer from chronic medical conditions such as diabetes, hypertension, and HIV/AIDS. These individuals can also be extensive users of health care services and are likely to receive care in high-cost settings such as emergency departments and inpatient hospital stays.

The traditional model of addressing homelessness focuses on providing temporary housing, which is often institutional or contingent on simultaneously addressing mental health or substance abuse needs. The short-term housing obtained with this approach might be lost if the individual no longer needs inpatient-level care or is not successful in reaching treatment goals.

More recently, some efforts to address homelessness have shifted to a "housing first" approach that prioritizes providing perma-

79%

Spending across public agencies in [Los Angeles] county was 79 percent lower for residents with supportive housing than for homeless people.

ment (or longer-term) housing that is not tied to success in treatment. Access to housing alone, regardless of efforts to treat problems that might contribute to homelessness, can have a positive impact and reduce the total harm to the individual. “Supportive housing” is an important component of that approach and is targeted toward individuals and families with chronic illnesses, disabilities, mental health issues, or substance use disorders who have experienced long-term or repeated homelessness. This type of housing intervention provides long-term rental assistance and access to supportive services to help keep individuals and families housed and to address other issues, including medical and behavioral health needs. Supportive housing assists individuals who were previously homeless obtain and maintain housing and also helps provide community housing to individuals who have been institutionalized.

Supportive housing can be provided under different models but that have a common set of underlying principles. Housing should be affordable, and tenants should not have to meet requirements unrelated to being a good tenant to maintain residency. Supportive services should be oriented toward keeping tenants housed; cover multiple disciplines such as physical health, behavioral health, substance abuse treatment, and social services; and be voluntary for tenants but offered assertively so that providers remain in contact with tenants who do not take advantage of help. Individuals in need of supportive housing might come directly from homeless situations or might be at risk of becoming homeless following an institutional stay and need supports to be able to live in a noninstitutional setting.

A project-based approach might house individuals in facilities designated for rental assistance and might include supportive services provided on site in those facilities. A tenant-based approach provides rental assistance to individuals who use that help to obtain housing in private buildings. The supportive services might be provided in a centralized location or through community providers.

The goal is to achieve the benefits of housing itself and make it more likely that the individual can sustain those benefits as well as have access to other services that will improve his or her health. The supportive services can help address a wide range of needs, including physical and behavioral health care, substance abuse, employment counseling, and commu-

nity integration. It might also include income and benefit supports.

Social factors such as physical environment—including housing, support networks, and socioeconomic status—are increasingly being recognized as having significant impact on health outcomes. For example, [Sandro Galea and colleagues](#) estimate that 20 percent of total deaths in the United States can be attributed to poor education, little social support, and poverty. With Medicaid as the primary health insurance program for low-income Americans and preliminary research indicating that the above factors affect the health of Medicaid beneficiaries, these factors are also expected to affect the demand for Medicaid services.

Medicaid can play a key role in supportive housing by funding some of the services needed by residents, such as behavioral health care and substance abuse services, as well as regular medical care. Such services are commonly covered by Medicaid, but with supportive housing, those services might be provided in new settings or by nontraditional providers or be better coordinated across providers and with other supports. By law, Medicaid cannot cover rent. Under certain waiver authorities, states can choose to cover housing-related services. These can include transition services, housing and tenancy sustaining services, and housing-related collaborative activities under Medicaid. Medicaid has long covered room-and-board costs in long-term care facilities, such as nursing homes, or intermediate care facilities for the disabled.

Interest from state Medicaid programs in supportive housing models was spurred by a US Supreme Court decision in 1999 (*Olmstead v. L.C.*, 527 U.S. 581) that said states must provide services for disabled individuals in the most integrated setting appropriate to the individual’s needs to comply with the Americans with Disabilities Act. In addition, since 2014 many homeless individuals have become eligible for Medicaid benefits for the first time, increasing the demand for supportive services.

Medicaid programs might also gain from having beneficiaries in supportive housing. Supportive housing might allow individuals to transition from more expensive institutional settings such as inpatient psychiatric facilities into community housing and might allow individuals to obtain more consistent treatment of chronic conditions in primary care settings so that they could reduce their

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number of emergency department visits and inpatient hospitalizations. For example, researchers have found that patients with housing have shorter hospital stays than homeless patients and that homeless patients have high readmission rates following an inpatient stay, with 70 percent of hospitalizations resulting in either another inpatient admission, observation status stay, or emergency department visit within thirty days of hospital discharge. A study of supportive housing in Los Angeles found that spending across public agencies in the county was 79 percent lower for residents with supportive housing than for homeless people. The majority of those savings came from reductions in spending on health care services, including a 91 percent reduction in average spending per month per person on certain inpatient hospitalizations and an 89 percent reduction in spending on emergency department services for individuals in supportive housing compared to spending for homeless individuals.

While a number of studies have shown health care or other social savings as a result of supportive housing, two systematic reviews of studies and articles on the costs and benefits of Housing First and supportive housing programs suggest that the evidence is promising but not conclusive. One Los Angeles study of supportive housing for veterans indicated that overall health care use was greater for formerly homeless veterans in supportive housing than for currently homeless veterans. It has been difficult to make definitive assessments regarding the impact of supportive housing because demonstration projects have usually been small; used different study designs; and have not always collected good usage, cost, and expenditure data.

The reduction in use of health care services and particularly in Medicaid spending can help offset the costs of operating supportive housing programs. An evaluation of an effort to increase supportive housing capacity in New York City found that overall the program produced net savings in government spending on health care services for tenants with supportive housing compared to people who were eligible for but not placed in the program. However, savings were not constant across the populations served. Most of the savings came from support for specific populations that were coming from state inpatient psychiatric facilities. Thus, the actual Medicaid savings were relatively small.

WHAT ARE THE OPTIONS?

States have a great deal of flexibility and numerous options of authorities and programs they can use to include supportive services, including supportive housing, as Medicaid benefits. The scope of services typically covered by Medicaid might not necessarily include long-term care or some other services that homeless individuals might require. The Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS) have highlighted different avenues available to states to leverage Medicaid funding to support housing programs. Many of these options are targeted toward individuals who have disabilities, which could include individuals who are identified as “chronically homeless” because they have a disability and extended or repeated periods of homelessness.

These materials do not reflect a change in Medicaid policy. Instead, they identify a variety of strategies on how states can use Medicaid funding to support individuals who are or have been homeless and emphasize options for covering housing-related services under Medicaid. Housing-related services can include transition and tenancy-sustaining services but not rent.

Covering services under a state plan. Each state Medicaid program has an agreement between CMS and the state (a state plan) that identifies the groups of individuals eligible for benefits, the services covered, and the payment methodologies. Some services are mandatory and must be covered, while others are optional services that states can choose to include or not. States can revise their state plans as needed to add coverage of optional services that support housing and to facilitate the furnishing of supportive services by providers serving the homeless population and in nontraditional settings.

For example, states have the option of covering rehabilitation services, targeted case management, and health home services. Rehabilitation services are medical or remedial services (mental health services to help patient behavior) that help individuals with physical or mental disabilities keep, regain, or improve their skills and functioning for daily living. Targeted case management services assist individuals in gaining access to needed medical, social, educational, and other services and can be targeted to specific beneficiary groups as defined by medical condition or geo-

565,000

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graphic region. Health homes are comprehensive systems of care coordination and health home services that include care management and coordination, transitional care from inpatient to other settings, and individual and family support. States might choose to provide these services in the hopes that they will improve the residents' ability to function, including maintaining housing, and help better coordinate other available means of support and care.

Some of that care might be furnished by providers that specialize in serving the homeless. States are required to cover services offered by federally qualified health centers (FQHCs), which include health centers that are funded by the Health Care for the Homeless Program. In addition to providing typical primary care and prevention services, FQHCs that receive Healthcare for the Homeless grants, administered by the Health Resources and Services Administration, provide services that include substance abuse treatment, case management services, and enabling services that connect patients to other supports, such as translation services and patient education. Some of these providers have started innovative programs that administer care "outside of the four walls" of the health center or use paraprofessional outreach workers to connect with the patient population. Outreach efforts might include peer-support specialists who also have experienced homelessness or behavioral health issues.

Transitioning these models of care to the Medicaid payment structure can be complicated since Medicaid services are typically provided by medical professionals operating in a clinical setting. State requirements for licensure and Medicaid restrictions on the types of individuals who can provide and bill for services can create barriers to innovation in this area.

Home and community-based services. States can include in their state plan, or request waivers from CMS to offer, home and community-based services, including housing-related services, to specific populations. These services could include housing transition and tenancy-sustaining services such as assessments of housing needs and assistance in searching for and securing housing as well as environmental modifications to make a specific location accessible. If an individual is transitioning from an institutional setting to a private residence, a state can cover community transition services under a 1915(c) waiver

that can include security deposits for a lease or utilities, household furnishings, and moving expenses. Similar services can be provided to individuals who do not require institutional-level care through coverage of home and community-based services in the state plan under 1915(i) authority.

The ACA created a new opportunity to cover person-centered attendant services under the Community First Choice option 1915(k). An enhanced federal match is provided for home and community-based services furnished to disabled individuals who qualify for institutional care. Covered services and supports can include items that increase an individual's independence and one-time expenses incurred during the transition from an institution to community housing. Five states have approved state plan amendments under this option: California, Maryland, Montana, Oregon, and Texas.

Other waivers and demonstrations. The ACA provided new authority for CMS to test innovative payment and service delivery models that have the potential to reduce expenditures under Medicare, Medicaid, and the Children's Health Insurance Program, while maintaining or enhancing the quality of beneficiaries' care. Models being tested include the [Accountable Health Communities Model](#), which will support efforts to increase awareness of and access to services addressing health-related social needs and assess the impact of those efforts on total health care costs, health outcomes, and quality of care for Medicare and Medicaid beneficiaries. Housing instability and quality and utility needs are two of the core areas that will be included in the comprehensive screening for health-related social needs that will be part of the project along with referral to community services.

The ACA also strengthened the Money Follows the Person Rebalancing Demonstration Program, which is intended to reduce institutional care and increase use of home and community-based services. States participating in this program have the option of offering housing-related services, and the most successful programs identified that the ability to cover one-time moving expenses and home and community-based services beyond what Medicaid typically covers and the need for additional support from transition coordinators as crucial elements. Forty-three states are participating in the program as of September 30, 2016.

“Individuals might not have the income and citizenship documentation necessary to prove eligibility.”

Operational issues. The brief summary above of some of the multitude of funding options for covering certain services under Medicaid highlights the operational complexity involved in ensuring that residents of supportive housing have access to needed services. For Medicaid to cover housing-related and other services, residents need to be eligible for Medicaid, and they have to be enrolled in the program. Individuals might not have the income and citizenship documentation necessary to prove eligibility and might not be able to obtain such documentation without a mailing address.

Basic principles that typically apply to Medicaid services would also apply to services received by residents of supportive housing. For example, Medicaid beneficiaries have freedom of choice of providers and therefore generally cannot be required to choose only certain providers, such as those affiliated with their housing project. (There are exceptions to this restriction for managed care plans.) Also, states must make services available not only to residents of supportive housing projects but to other Medicaid beneficiaries with similar needs; this can increase the scope and cost of covering such services.

Each of the options described above has its own specific requirements to obtain federal Medicaid funding, and only certain individuals can be served under many of these avenues. A supportive housing resident might qualify for services under more than one option. Determining whether and how an individual can be served can be complicated. In addition to determining coverage for Medicaid services, if available, those services also need to be coordinated with the services provided under other programs and authorities that address other needs, including housing itself, transportation, and nutrition.

To achieve desired savings either to reduce state spending or to have funds to reinvest in housing or supportive services, programs might have to target those populations for whom supportive housing is most likely to reduce Medicaid spending. Such populations include individuals who are likely to use institutional services. While there might be some data available on the services used for homeless individuals who previously had Medicaid coverage, it is not always possible to predict future use of services for transient populations because of limited information on previous needs or services used.

WHAT ARE STATES DOING?

To use Medicaid to support the broadest population that might be eligible for supportive housing, states need to have expanded Medicaid to include low-income, childless adults. Individuals in states that have expanded Medicaid eligibility are more likely to be able to use Medicaid to access supportive services. Thirty-one states and the District of Columbia have expanded their Medicaid programs since 2014, but nineteen states have not. Chronically homeless individuals in states that have not expanded access can likely only qualify for Medicaid if they can demonstrate that they have a disability that would qualify them for Supplemental Security Income (SSI). Qualifying for SSI can be particularly difficult for individuals without access to their medical records or other needed documents and with no address to which such documents could be delivered.

In 2012 almost all states had 1915(c) waivers to provide home and community-based services as an alternative to institutional care. (The four states that do not have 1915(c) waivers—Arizona, Hawaii, Rhode Island, and Vermont—cover home and community-based services under waiver authority for managed care.) However, in most states that were covering services under 1915(c) waivers, those services were available only to certain populations. The most commonly covered populations are the elderly, people with intellectual or developmental disabilities, and people who are physically disabled. The population least likely to be eligible for 1915(c) waivers are those with mental illness, which could limit the availability of services to some residents of supportive housing.

A recent report from HHS describes how six states and localities have used Medicaid to provide services needed by residents living in supportive housing. The authors of the HHS report recognize the complexities of using Medicaid for this purpose but emphasize the value of Medicaid as a funding source for meeting the needs of supportive housing residents.

Some states are also tackling health care delivery system reforms that might incorporate nonmedical support services. Under Medicaid accountable care organizations (ACOs), provider organizations bear financial risk for the care furnished and are held accountable for the health outcomes of their assigned patient

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population. ACOs might receive capitated pay-
ments or a share of savings from reductions
in Medicaid spending, creating a financial
incentive to ensure that the patient's care is

well coordinated and effective. ACOs in Wash-
ington, Oregon, and other states have social
service provisions including supportive hous-
ing in their models. ■

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