ACAP
Association for Community Affiliated Plans

Breaking the Health and Housing Silos to Address Chronic Homelessness

June 2018

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CHAPTER 1

Executive Summary

The United Nations' Declaration of Human Rights states, "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control."[1] And yet, according to the U.S. Department of Housing and Urban Development (HUD) "on a single night in 2016, 549,928 people were experiencing homelessness in the United States. That translates to about 1 in 500 people in the United States being homeless on any given night. 16 percent of these individuals are considered *chronically* homeless.[2] 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."[3]

While the very definition of chronic homelessness is tied to one's health, housing and health authorities continue to grapple with the issue in silos. The U.S. Department of Housing and Urban Development states, "[S]table housing is fundamental to both maintaining good health and minimizing the costs of unnecessary emergency room utilization and hospital admissions."[4] Despite this awareness, interventions to address the homelessness crisis continue to exist independently of one another and as Band-Aid solutions. The declining stock of affordable housing exacerbates the problem as housing subsidy wait-lists continue to rise. According to the Urban Institute, in 2015, there were only 28 adequate and affordable housing units available for every 100 renter households with incomes at or below 30 percent of the area median income.[5]

Coupled with this, the 2010 passage of the Affordable Care Act and the increasing Medicaid-eligible homeless population brought to light the pressing need for health and housing agencies to come together to not only reduce costs, but to improve the lives of this historically underserved population. In the absence of federal policies to tackle homelessness, health plans are developing innovative solutions and investing in efforts to address these social determinants of health which go outside the traditional boundaries of health care.

This paper highlights 10 of the 61 health plan members of the Association for Community Affiliated Plans (ACAP) that are leaders in addressing the needs of their homeless populations and developing initiatives that address the social determinants of health. It summarizes federal Medicaid and housing laws that impact homeless Medicaid recipients and outlines a variety of solutions health plans have implemented, taking into consideration the challenges they continue to face.

Notes

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CHAPTER 2

Introduction

People experiencing chronic homelessness typically have complex comorbidities, such as mental illness, substance use disorders, physical disabilities and other medical conditions.[6] Their homelessness may exacerbate their health conditions and they are often not effectively engaged in treatment for their conditions, as their priorities are focused on finding food and shelter.[7] They may be distrustful of treatment centers or health care providers, and may find it difficult to access care or participate in treatment programs. Studies find that compared to stably housed individuals, people experiencing homelessness are more likely to visit the emergency room, have a longer stay if they are admitted to the hospital, and are more likely to be readmitted within 30 days.[8] One study finds that homeless individuals are three times more likely to use the emergency department at least once per year compared to the general population.[9]

While homeless enrollees' access to care has improved in the 32 states that opted to expand Medicaid under the Affordable Care Act, a number of challenges persist. Many homeless individuals remain uninsured because they need substantial assistance not only with the application and enrollment process, but also with the redetermination process. In addition, access to care alone cannot improve these individuals' health outcomes. Poverty, hunger, unemployment and lack of housing also need to be addressed. Providing housing to these individuals would reduce costs by preventing repeat hospitalization and emergency room visits. "Lack of housing has implications for hospitals who incur longer lengths of stay and higher readmissions when patients have no safe discharge options."[10] The U.S. government has implemented a number of health and housing policies to address the unique needs of this marginalized population.

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CHAPTER 3

Federal Health Policies

In 2003, the U.S. Department of Health and Human Services (HHS) first committed to ending chronic homelessness, and released their plan entitled "*Ending Chronic Homelessness: Strategies for Action*."[11] As a result, the government invested Medicaid dollars in Permanent Supportive Housing (PSH) using the Housing First model. PSH provides subsidized housing with wrap-around services to homeless individuals with disabilities and chronic conditions in an effort to promote long-term stability and improved health outcomes.[12] Housing First uses a "screening in" versus "screening out" approach to housing chronically homeless individuals and removes previously existing conditions to being eligible for housing. Mounting research demonstrates that using PSH in a Housing First approach is the solution to chronic homelessness.[13] From 2007 to 2017, investments in PSH have decreased the number of chronically homeless individuals by 27 percent.[14]

Medicaid is one of the top three funders of services offered at PSH sites.[15] Gains in Medicaid coverage through the ACA's Medicaid expansion are leading to increased Medicaid revenues that are "supporting longer-term strategic and operational improvements focused on quality, care coordination, and information technology."[16] Furthermore, the Medicaid expansion has been tremendously advantageous for childless homeless individuals, who had previously been ineligible for Medicaid coverage and lacked access to essential health care services such as primary care, mental health services, substance use treatment and transportation to medical appointments.[17]

The ACA also introduced Health Homes, an optional state benefit program aimed at coordinating care for Medicaid beneficiaries with comorbidities, many of whom are likely to be homeless.[18] According to the federal Department of Health and Human Services (HHS), "Health Home providers will integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person." In order to be eligible for a Health Home, the Medicaid beneficiary must have one of the following: "Have 2 or more chronic conditions; Have one chronic condition and are at risk for a second: Have one serious and persistent mental condition."[19] As of June 2017, 21 states and the District of Columbia have Medicaid Health Home programs, with more than one million Medicaid beneficiaries enrolled in the programs.[20]

Alternatively, Section 1115 Medicaid Demonstration of the Social Security Act allows states to develop innovative pilots to address problems that differ from what is traditionally approved under Medicaid.[21] States can use Section 1115, accordingly, for certain housing-related services. These include "helping the individual problem-solve, advocate with landlords, access community resources to assist with back rent, and assist individuals to complete forms for subsidized housing."[22] California used the 1115 waiver to launch their "Whole Person Care Pilot" in 2016. The goal of the pilot is to coordinate physical and behavioral health with social services in an effort to improve Medi-Cal beneficiaries' health outcomes. Eighteen pilots were approved by the California Department of Health Care Services (DHCS), with a total five-year budget of $1.5 billion.[23] The pilot requires the application to include participation of at least one managed care plan and public housing authority for pilots that include housing services.[24] 14 of the 18 pilots target individuals experiencing homelessness or that are at risk of becoming homeless. Many of the pilots are still in their development phase and are evolving. These pilots' evaluations will have profound implications for health and housing policies.

While perhaps more relevant to efforts to improve housing transitions from institutionalized to community settings for patients receiving long-term services and supports, the American with Disabilities Act (ADA) has also had significant impact on efforts to address chronic homelessness. Title II of the ADA requires public entities to administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities. This provision is the central question in 1999 *Olmstead v. L.C.*, a Supreme Court case which significantly changed the landscape of community-based services. While *Olmstead* did not change Medicaid law, it significantly influenced the delivery of Medicaid services, given that Medicaid is the major payer for long-term services and supports (LTSS), including home-and community-based services (HCBS).[25] Research demonstrates that "individuals experiencing chronic homelessness often find themselves caught on an institutional circuit, cycling between shelters or life on the streets and

institutional psychiatric treatment facilities, inpatient hospitals, nursing facilities, jails, and prisons. Likewise, individuals with disabilities who leave institutions without access to housing and services they need to achieve stability are at risk of becoming homeless. In fact, it is possible for a person with a disability to be both at risk of institutionalization or institutionalized and to be experiencing chronic homelessness at the same time."[26] While, transitional homelessness is addressed in ACAP's "Bridging the Health and Housing Gap Paper", it is important to call out that the two populations are heavily intertwined, and many times one and the same.

By law, Medicaid is prohibited from covering rent, but under certain waivers states can cover housing-related services. For example, under Medicaid's 1915(c) Home and Community Based (HCBS) Waiver Program, housing transition and tenancy-sustaining services can be covered for people that meet institutional settings of care. These include help with searching for and securing housing, security deposits, establishment of utility accounts, and basic home furnishings. Benefits under Section 1915 can be accessed through other waiver programs:

- Medicaid's 1915(b) waiver gives states the option to offer HCBS to individuals with disabilities, adults needing long term services and supports (LTSS) and individuals experiencing homelessness.[27]

- Under the 1915(i) waiver, states can offer HCBS to people with disabilities or behavioral health issues who need less than an institutional level of care.[28]

The 1915(k) waiver, also known as the Community First Choice, gives states the option to provide HCBS to people who are eligible for Medicaid and have incomes below 150 percent of the Federal Poverty Level, but who do not meet the institutional level-of-care criteria. It also provides HCBS to individuals who meet the institutional level-of-care but whose income exceed 150 percent of the Federal Poverty Level.[29]

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CHAPTER 4

Federal Housing Policies

To understand the complexity of the housing and health realms, we must also take into consideration federal housing policies. These policies tend to fall into one of three categories: "(1) programs that provide deep, gap filling rent subsidies, earmarked either for particular buildings or for individual households; (2) tax credits that produce new housing with moderate (below market) rent levels; and (3) block grants that provide flexible support for local affordable housing initiatives."[30]

The Housing Choice Voucher Program (also known as Section 8) is one of the most successful HUD-funded programs that falls into the category of rent subsidies.[31] People and families with incomes at or below 50 percent of area median income receive a voucher to use toward the housing of their choice, provided it meets program requirements. At least 75 percent of vouchers go to households with incomes below 30 percent of the area median income. The subsidies are long-term and are considered permanent housing. Eligibility requirements for Section 8 vary by state, and do not necessarily align with Medicaid eligibility requirements. For example, someone who makes $30,000 a year in Rockland County, New York would qualify for Section 8 housing, but not for Medicaid, where you would need to make $16,394 or less to qualify (see Table 1 below).[32]

A separate program, Section 202, provides funding to support multifamily housing for the very low-income elderly.[33] Section 202 is the only federal program that specifically addresses the need of affordable housing for the elderly. In 2004, the federal government allocated $20 million to create the Section 202 Demonstration Program. This partnership between HUD's Office of Multifamily Housing Programs, the Office of Policy Development and Research with Congress and HHS examines the Medicare and Medicaid expenditures of 12 cities to evaluate the potential of HUD programs to reduce health care use and expenditures among the low-income elderly.[34]

Another housing program, the Section 811 Supportive Housing Program, provides funding for disabled, low-income households. Section 811 provides interest-free capital advances and operating subsidies to not-for-profit developers who build housing for individuals with disabilities.[35] More than two-thirds of Section 811 residents who have come from nursing homes, hospitals or other specialized residences have developmental disabilities and chronic mental illness. Many of these people are at risk of homelessness or have experienced chronic homelessness. One important feature of Section 811 is the Frank Melville Supportive Housing Investment Act of 2010. Under this Act, new project rental assistance funding was provided to State Housing Agencies to create integrated supportive housing, on the condition that they work with the State's Medicaid agencies--an encouraging step towards integrating the two.[36]

The Low-Income Housing Tax Credit (LIHTC), that falls into the category of tax credits to spur affordable housing development, is another policy that substantially impacts the housing market for low-income individuals. Created in 1986 and administered by the Internal Revenue Service (IRS), this program provides tax incentives to developers to create affordable housing units. The program is the largest source of affordable housing in the nation. As of 2017, there were two million tax-credit units nationwide, with approximately 100,000 units being added per year.[37]

Finally, the HOME Investment Partnership Program (HOME), established by HUD, falls into the category of housing assistance. HOME provides block grants to states and localities, often in partnership with not-for-profit organizations, to help fund the payment for or rehabilitation of affordable low-income housing units. HOME is the largest Federal block grant designed for this purpose.[38]

Early Health and Housing Integration Successes

While the integration between health and housing policies are just beginning to surface, a model for bridging the two silos is the partnership developed between Veteran Affairs Medical Centers and Public Housing Agencies (PHA).[39] The agencies came together to create the HUD-VA Supportive Housing program (HUD-VASH). HUD-VASH combines Section 8 Housing choice rental assistance with supportive services and comprehensive case management provided by the VA. Veterans experiencing homelessness enter the program through assessments at VA medical centers, and achieve assistance from both programs working together. The VA and HUD work jointly to assess performance against set targets. From 2010 to 2016, veteran homelessness declined by 47 percent.[40]

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CHAPTER 5

Case Studies: ACAP Plans' Innovations

In the absence of strong federal health and housing partnerships, health plans have developed innovative solutions to help fill the void. The ten ACAP health plans interviewed below highlight various ways plans are addressing social determinants of health among their homeless and chronically homeless populations.

The first step towards addressing the needs of individuals experiencing homelessness is through identification. All ten health plans interviewed face difficulties in identifying these members. Most health plans use generic methods to identify their homeless populations. These include looking at ICD-10 codes for homelessness, three or more addresses in one year, or the following listed in the address data file: "homeless", "no address", "no home" and "unknown", as well as self-identification through health assessments.

Amida Care, on the other hand, has a unique advantage in the identification of individuals experiencing homelessness, as the plan receives a weekly census roster from the New York City Department of Homeless Services (NYC DHS) with notification of a current member's homeless status. (Some members who have become homeless as per NYC DHS will not appear on this roster for at least 30 days.) In addition, the plan may also receive attestation of a member's homeless status by a community-based provider.

A select few of the plans interviewed have developed creative and innovative solutions to better identify individuals experiencing homelessness. For example, UPMC *for You* and L.A. Care have collaborated with the local housing departments to create a data exchange system to provide more effective and appropriate care for some of their most disadvantaged members. UPMC *for You* collaborated with a local HUD contractor – Community Human Services (CHS) – to establish a data sharing program to match members with high unplanned health costs who are also chronically homeless, as defined by HUD. Similarly, L.A. Care's Safety Net Initiatives and Social Services departments developed a partnership with the Los Angeles Homeless Serving Authority to obtain read-only access to the authority's Homeless Management Information System database. This enables L.A. Care's social workers and care managers to pull up an individual member's history in the housing authority system to make more informed referrals and recommendations. L.A. Care also created a data-sharing agreement with the local Housing Authority to match individuals who are both members of the plan and have utilized housing services.

UPMC *for You* and L.A. Care successfully working through the privacy barriers between the agencies was a crucial first step in bridging the divide between housing and health authorities to deliver more comprehensive, better-coordinated services. Through these developments most health plans are not only able to more effectively identify members experiencing homelessness, but are also able to create and refine new programs to help address the homeless crisis existing in their respective areas of coverage. While identification of individuals experiencing homelessness remains a key challenge, health plans are developing innovative solutions to help members who have been identified.

There are several other challenges that resonate across all plans. First and foremost, the affordability and availability of housing remains the biggest barrier to helping house homeless members. Coupled with this, waiting lists for Section 8 housing continue to increase. Another barrier that all plans face is the ability to use Medicaid dollars to fund housing costs combined with strict eligibility criteria set by housing providers. For example, some only serve veterans or low-income families with children, which restricts many homeless members from receiving the same level of supportive services.

Housing applications remain complicated and difficult to navigate through. Some health plans, such as Boston Medical Center HealthNet Plan, have mitigated this challenge with the support of Community Health Workers (CHWs). CHWs help members through the often-complicated housing application process and with necessary tasks such as clearing up credit issues and criminal record reviews that can make the difference between securing housing and remaining homeless. In addition, lack of support services (to include case management, independent living skills, vocational skills, peer support services, among others) to ensure members remain housed continue to be a barrier to keep individuals experiencing homelessness housed. Moreover, many of these individuals also have multiple

chronic conditions and a high prevalence of disabilities, which makes supportive services that much more critical to their well-being.

Individuals with criminal records may also be precluded from subsidized housing, which ultimately results in these members becoming homeless once released from prison. Many homeless members suffer from mental illness and cognitive disorders that make navigating the housing and health systems even more challenging. Finally, a large portion of this population is uneducated and unaware of how to access resources and services that will enable self-sufficiency.

Another barrier to care is that homeless members move around and can be difficult to find, making consistent communication between the member, providers, and the plan's staff difficult. This impedes care access and the plan's ability to help homeless members navigate the complex health care system. Furthermore, homeless members face stigma when accessing primary care. In one study of homeless veterans, individuals stated they avoided primary care settings as a result of the following reasons: 1) trust – "I don't trust doctors"; 2) stigma – "they treat me poorly when I go there; and 3) care processes – "I'm always assigned to student doctors."[41] Therefore, stigma further reinforces their alienation from a system that should help them and reduce avoidable emergency room visits, which produce higher costs and result in inconsistent care.

Another unique challenge faced by Amida Care is that once homeless members have been stably housed and consistently in health care for one year, they are no longer eligible for membership in a Special Needs Plan. This disrupts the continuity of care and the trust and relationship established between the member and provider. It is also a disincentive for clinic-based counselors to enroll individuals with Amida Care, as they will later have to transfer the individual to another plan.

Finally, working across different sectors, such as housing and health agencies, and the complexity and variations of data systems continue to remain a barrier. Without a holistic health care system, caring for homeless members, in the current fragmented system remains challenging.

While all health plans interviewed face these common challenges, they have developed diverse and innovative solutions to mitigate these challenges that are discussed below.

Partnership HealthPlan of California

Partnership HealthPlan is a not-for-profit community-based managed care organization located in Northern California, which serves approximately 560,000 Medicaid recipients across fourteen counties. The plan estimates that about 1 in 20 of its Medicaid members are homeless. As a result, they recently invested $25 million in a housing grant initiative that aims to address housing and wrap-around service needs. The plan awarded grants ranging from $50,000 to $5 million to the Department of Health and Human Services, Sonoma County Community Clinic, CAP of Solano, JPA, the City of West Sacramento, among others. Projects range from rapid rehousing, housing stabilization, homeless prevention, and development of building acquisition-rehabilitation that houses Partnership Health Plan members.

Partnership HealthPlan also runs an Intensive Outpatient Primary Care Management program, modeled after Health Homes, that provides wrap-around services for members with complex conditions. While homelessness is not a requirement, many program participants are homeless. Many of the plan's clinics (some of whom also happen to be "Healthcare for the Homeless" grant recipients), counties and local housing agencies or city governments are partners in these services.

Partnership Health Plan finds innovative ways to connect its staff with their homeless members. Since 2014, the plan has collaborated with Project Homeless Connect in its Community Day of Service across several counties. The Community Day of Service is a day where homeless members gather to receive a wide range of services, including "medical, optical, dental, DMV identification cards, housing, employment, clothing, showers, haircuts, and even veterinary services." In 2017, 406 homeless members participated in the event, of which 315 (78%) spoke to at least one of Partnership's Member Services representatives. 254 of the 315 (81%) individuals were identified as being a Partnership Plan member, while 104 (41%) of the identified members were able to receive health insurance due to Medicaid expansion. Some of the participants did not know they could receive health coverage. Others who were covered were unaware of the many benefits offered by Partnership Health Plan.[42] Hence, connecting with homeless members and educating them on their benefits and resources is one important step towards addressing social determinants of health.

CareSource

CareSource is a not-for-profit managed care plan based in Dayton, Ohio, that serves approximately two million Medicaid members across Ohio, Indiana, Georgia and Kentucky. CareSource has estimated that roughly 26,000 members, 1.3 percent of their membership, is homeless.

CareSource is a pioneer when it comes to addressing social determinants of health. Through the creation of their Life Services Department they have established programs that not only address housing, but also employment, food insecurity and other social obstacles. As the plan's former CEO, Pam Morris states, "From the beginning of CareSource, we were acutely aware that our members who were living in poverty had many struggles. Most were basic needs, such as food, housing, paying utilities; for others, it was having stable employment."[43] Life Services provides wrap-around services that include "life coaching, education, financial assistance, soft skill development – such as communication and interviewing techniques – as well as job training, among other things."[44]

Life Services' Job Connect program pairs members with a life coach, who connects members with wrap-around services tailored to meet each member's needs. The life coach conducts individualized risk assessments, case management and addresses the members' social determinants of health, in an effort to identify and resolve obstacles to members' long-term employment and self-sufficiency. The life coach also helps members with necessary resources to ensure long-term employment. These include emotional support, food stability, childcare and physical or mental health care services. As of December 2017, 11,230 Members had interacted with Life Services. 1,711 members had opted into Life Services, 1,639 were actively working with coaches, 5,016 were referred to community resources and 635 were employed. 86% of those employed have retained employment.[45]

In Ohio, CareSource, CelebrateOne, the Ohio Finance Agency, Columbus Metropolitan Housing Authority and other organizations have developed the "Healthy Beginnings at Home" pilot, a pilot that targets homeless or near homeless pregnant women. The two-year pilot, financed by the Ohio Finance Agency (with CareSource contributing $250,000) is designed as a controlled study that targets 100 homeless pregnant women. Fifty women will receive rental subsidies, housing stabilization services and community-based services, while another fifty will only receive community-based services. Housing stabilization services include funding for furniture, utility setup, application feeds, security deposits, housing selection assistance, and educating members about tenant rights, finance management and other tenancy trainings.[46] Community-based services offered include CareSource's JobConnect program to help women find jobs. The program intends to shed light on whether having stable housing improves birth outcomes, reduces infant mortality and improves health outcomes of expecting and new mothers.[47]

The program is divided into four phases. The first 30 days involves engaging the mother through needs assessments, personalized plans and connecting them to safe and affordable rental apartments. It includes move-in assistance, furnishing, fully-subsidized rent for the duration of the program, tenancy and financial education, weekly community health worker home visits and CareSource coordination. The second phase continues the home visits and features income stabilization services, financial coaching, screening and referrals to appropriate resources, food and nutrition assistance, education programs for children and family planning and parenting classes. Over the next six months, mothers are appropriately connected to resources in the community, and educated in breastfeeding, infant care and childcare. If the mother cannot find employment, the program pays the rent until the mother is able to return to work. In the fourth and final phase, the family starts paying rent to the landlord, with a few tactics in place to ensure the families remain housed. These include "emergency assistance funds, financial coaching and budgeting, payment plans, service referrals, behavioral education (e.g. housekeeping coaching), on-going benefits and screening and employment services."[48] CareSource hopes that by participating in this program, it will pave the way to help more homeless women.

In 2016, under contract with the Ohio Department of Mental Health & Addiction Services, CareSource also began leading the Community Transitions Program. This program supports the transition by individuals with substance use disorders from prison to life in the community. The program provides a transitional benefit that includes pre-release care-planning, linkage to a network of community substance abuse treatment providers, and access to recovery services such as housing, supported employment, peer recovery support, transportation and life skills. The program identifies individuals at high risk of homelessness prior to release from prison and matches them to housing interventions including permanent supportive housing, rapid rehousing and recovery housing. [49] The program has housed over 450 members. These members have the potential to become homeless, and programs like these target housing barriers to assure the plan is not only

mitigating the effects of homelessness, but also taking steps to prevent it.

Finally, CareSource hopes to further help their Ohio homeless membership through mental health services. While mental health is currently carved out of managed care in Ohio, Ohio is moving to have managed care organizations administer the mental health benefit by July 2018. This may also prove to help their homeless members that face mental health issues, as the plan will have more access to data that is difficult to access across different entities.

Boston Medical Center HealthNet Plan/Beacon Health Options

BMC HealthNet Plan is a not-for-profit managed care health plan based in Boston that serves about 150,000 Massachusetts Medicaid (MassHealth) members. BMC HealthNet Plan has estimated that approximately two percent of its Medicaid members are homeless. It partners with Beacon Health Options (Beacon) to provide behavioral health services; together, they evaluate the impact that severe mental illness has on its homelessness population, providing them to have a more holistic view of their members.

BMC HealthNet Plan, in conjunction with Beacon, has adopted several programs to address the needs of its homeless population. These include the Community Support Program for People Experiencing Chronic Homelessness (CSPECH), Pay for Success, and the Hospital to Housing program.

CSPECH began in 2005 as a partnership between not-for-profit policy advocacy organization the Massachusetts Housing & Shelter Alliance (MHSA) and the Massachusetts Behavioral Health Partnership, now a division of Beacon. In 2016, CSPECH was expanded to serve MassHealth members that are enrolled in health plans that partner with Beacon, including BMC HealthNet Plan. CSPECH was developed under the authority of the 1115 waiver. It provides supportive services to individuals who meet the U.S. Department of Housing and Urban Development (HUD) definition of chronic homelessness and who have been placed in permanent supportive, low-threshold housing. These services are meant to help members attain life skills and access community resources in order to remain housed and improve health. Services provided include help with daily living skills, transportation, connection to health care and other services, and case management services. A recent analysis of CSPECH determined that:

- There was an average decrease of $226 per person in MassHealth costs in the month immediately following the start of CSPECH services. This decline continued so that by one's 24th month in CSPECH, monthly costs were $765 lower than in the month prior to CSPECH entry.
- Among the 1,301 individuals in CSPECH who were part of this study, significant reductions in behavioral health and medical costs led to an overall reduction in MassHealth costs of $11,914 annually per person.
- For this same group, annual per person net savings were $7,013. Each dollar spent on CSPECH yielded a return on investment of $2.43, due to the reductions in non-CSPECH MassHealth costs that more than offset the cost of CSPECH services.[50]

As Joe Finn, the President and Executive Director of MHSA states, "Housing with supportive services has a profound stabilizing effect on members - it's like a vaccine for high utilization."[51]

The Pay for Success (PFS) initiative, also known as Social Innovation Financing (SIF), is another program that benefits homeless BMC HealthNet/Beacon members. Since 2015, PFS/SIF has successfully engaged health plans in efforts to expand permanent supportive housing opportunities for their members. Administered by MHSA, PFS/SIF leverages a mix of philanthropic funding and private investor capital from United Way, Santander Bank and the Corporation for Supportive Housing to provide upfront funding to underwrite housing efforts for 500 to 800 chronically homeless individuals over the next six years. It also leverages public resources, including Massachusetts Rental Voucher Program subsidies from the Department of Housing and Community Development, and relies heavily on CSPECH to cover the services necessary to keep chronically homeless individuals stably housed.

CSPECH and PFS/SIF show the power of collaboration among the health care and housing sectors. As noted throughout this paper, organizations that secure housing for chronically homeless individuals need dollars to pay for the intensive services needed by this population, and managed care plans need housing resources for their homeless members. With programs like CSPECH and PFS/SIF, both housing and health care entities are coming together to provide a more comprehensive level of care for members that brings profound success.

Generally, members are referred into CSPECH and PFS/SIF by providers of housing to the homeless, and Beacon keeps track of these members through claims. While Beacon and BMC HealthNet Plan are not typically involved in referrals, there may be instances where case managers at the plan may refer individuals into the programs. One element of CSPECH that has proven to be a challenge is that chronically homeless Medicaid members who are also Medicare recipients not eligible for the program. Many CSPECH providers have willingly served this population anyway. Yet this may be a disincentive for providers, as they need to pay for both housing and services out of their own budget, which may prove to be unsustainable in the long run.

A third initiative that serves chronically homeless BMC HealthNet/Beacon members is the Hospital to Housing (H2H) program. H2H is a three-year grant funded by the United Health Foundation which aims to identify 250 chronically homeless members and house at least 100 of them over the course of three years. The program is a partnership between MHSA (the grantee), and Beacon Health Options. It targets homeless adults with serious mental illness and a history of behavioral health inpatient admissions. The goal of the program is to reduce hospitalization and emergency service usage of this population by connecting them to permanent supportive housing.

MHSA partners with Beacon to hire, train, and deploy five community health workers (CHWs) to "embed" at homeless service providers in three different geographic locations in Massachusetts. The CHWs are employees of Beacon and their role is to find chronically homeless members eligible for the program and connect them to housing and supportive services.[52] CHWs act as system navigators, guiding and supporting members through the often complex and overlapping worlds of housing and health care.

Well Sense Health Plan

Well Sense Health Plan is a not-for-profit managed care organization operated by Boston Medical Center HealthNet Plan, Inc. The plan serves about 70,000 Medicaid recipients in New Hampshire. Well Sense has determined that about 1 in 300 of its members are homeless.

Once identified, homeless members are enrolled into Well Sense's complex care management program. The program looks at individuals and the population from a holistic perspective, "emphasizing psychosocial support, self-management goals, care coordination, ongoing monitoring, and appropriate follow-up care."[53] In 2016, Well Sense established "buddy" teams consisting of both medical and social work staff. Through this buddy system Well Sense hopes to not only meet whole-person needs, but also improve cross-departmental and agency collaboration.[54]

Well Sense also conducts face-to-face home visits, or what they call their "Feet on the Street" initiative. These face-to-face home visits can occur anywhere including a clinic, shelter and public areas. By observing a member in his or her living environment, a case manager can make much better-informed determinations as to which resources and services are appropriate.[55]

Well Sense's case management department is very well connected to community organizations. and these networks enable them to make referrals and ensure homeless members are receiving the wrap-around and housing services they need. Two not-for-profit organizations with which Well Sense has formed strong connections are the Families in Transition program and New Horizons. Founded in 1991, Families in Transition (FIT) strives to utilize innovative and effective strategies to not only help house homeless individuals, yet also provide meals, substance abuse treatment and find strategies end the homelessness cycle by creating self-sufficiency.[56] Established in 1973, New Horizons is an adult homeless shelter, a soup kitchen, a food pantry and a shelter for women. Its other services include substance abuse counseling and mandatory case management sessions, where shelter clients meet with New Horizons case managers to develop goals and self-sufficiency.

Well Sense faces steep challenges in locating its homeless members. This is a common barrier for health plans. Well Sense is taking steps to address this ongoing challenge by offering a cell phone to members enrolled in Well Sense's case management program who do not have active or reliable phones. Well Sense has a contract with Sprint and the plan covers the monthly cost of these cell phones, which are programmed to dial a limited set of phone numbers. These include the Well Sense Member Services Department; the member's providers and care team; community organizations; Beacon Health Strategies, Well Sense's behavioral health vendor; and 911. As Well Sense states, "These phone offerings increase engagement that enables us to better identify broader social or economic factors and can negatively impact access to care."[57]

Community Health Group

Community Health Group (CHG) is a not-for-profit managed care organization based in San Diego. The plan serves CHG's case management department and does in-person face to face visits with their complex case management members, many of whom are homeless or are at risk of becoming homeless.

Community Health Group has led and participated in a number of initiatives designed to provide housing to their homeless population. CHG was a key stakeholder in Project 25, a San Diego county collaborative. A three-year housing pilot that launched in 2011, Project 25 targeted homeless individuals who were high utilizers of the emergency department, hospitals, jails and ambulances. The goal of the program was to identify the county's 25 highest users of emergency and medical services and house them using the Housing First model. Everyone in the program was provided a HUD-subsidized apartment as well as services provided through the county mental health department or St. Vincent de Paul, a not-for-profit homeless service provider. The program only targeted 25 homeless members. Nevertheless, it was a huge success and gained national recognition. In 2013, two years after the launch of the program, "Project 25 participants took 600 fewer ambulance rides, were in the ER 1,100 fewer times and spent nearly 1,000 fewer days in the hospital compared with the year before they entered the program," a savings of more than $2 million. To date, three Project 25 participants have died of natural causes. None have returned to the streets.[58]

CHG is also heavily involved in the Whole Person Care Pilot in California. The five-year pilot, approved under Medi-Cal's 2020 waiver, attempts to coordinate health, behavioral health and social services in a patient-centered manner in an effort to improve health outcomes of Medicaid's high utilizers. San Diego's Whole Person Wellness program is modeled after Project 25 and is set to be implemented in 2020.

UPMC *for You*

UPMC *for You* is a not-for-profit, physical health managed care plan based in Pittsburgh which serves approximately 500,000 Medicaid members. An estimated 1,500 individuals are homeless each year in Allegheny County and often face crippling barriers to receiving the health care they desperately need. While it is often difficult to identify which members are homeless, discussions with medical providers, care coordination staff, members and families, estimated that approximately 40 to 50 of UPMC *for You's* Medicaid and Special Needs Plan member are homeless and have high unplanned care spending. UPMC *for You* also uses claims data, case management data and address information to identify homeless members.

After identifying eligible members and in partnership with Community Human Services (CHS), a Pittsburgh community-based organization whose mission is to empower individuals and families to live in stable housing, connect to community resources, build relationships, and access quality food, UPMC *for You* launched the Cultivating Health for Success Program in 2010. To be eligible, individuals must be a UPMC *for You* member, chronically homeless as defined by HUD, have high unplanned health care costs and be willing to work with care managers toward living independently. The program has three main elements: permanent supportive housing, an assigned medical home, and intensive case management and care coordination. To improve case management, members are not only seen by staff located at the primary care office, but also by community-based registered nurses and social workers. The goal of the program is to ensure members have a safe place to live with appropriate medical, behavioral and social support.

To date, the program has been incredibly successful, particularly when measured against the Triple Aim: "improving the health of the population, enhancing the experience and outcomes of the patient, and reducing per capita cost of care for the benefit of communities."[59] Over the first five years of the program, 51 of the 60 targeted members were successfully housed, with estimated cost savings averaging $6,384 per housed member per year. This accounts for increased pharmacy costs of $2,088 per member per year, which likely indicates improved medication adherence. Data from 2015 and 2016 demonstrate that members enrolled in the program and receiving housing via HUD had 42% fewer unplanned emergency visits and hospital admissions compared with those not receiving HUD housing. In addition, members who were enrolled in the program but not housed had an increase in medical expenditures and a spike in unplanned hospital visits,

indicating that savings only occurred when members were housed in a stable living environment with wrap-around services.

While Cultivating Health for Success has demonstrated a positive impact for individuals, the health plan and the community, continuing to properly identify those who are homeless and providing integrated, whole person care are challenges that UPMC for You hopes to tackle in the years ahead.

L.A. Care Health Plan

L.A. Care Health Plan is the nation's largest publicly-operated health plan with more than two million members in Los Angeles County. L.A. Care provides coverage through four programs: Medi-Cal; L.A. Care Covered, the plan's Marketplace product; Cal MediConnect, part of the state's duals demonstration; and a PASC-SEIU plan for home care workers. While L.A. Care has historically understood the importance of the Social Determinants of Health through various initiatives, they have also recently developed a Social Determinants of Health Workgroup, and outlined five key areas they will focus their efforts, one of which is housing.

L.A. Care's Safety Net Initiatives Department developed an algorithm to query L.A. Care's databases to predict which of its members were at elevated risk for experiencing homelessness. The results of this analysis, coupled with the 2017 Los Angeles Homeless Count, has led L.A. Care to estimate that approximately 60,000—or three percent of their Medicaid membership—will experience an episode of homelessness over the course of a year.

L.A. Care is in the process of developing a homeless indicator to the front-end application that clinical staff use, to have a consolidated place to share information on social determinants of health and ensure members are being appropriately triaged.

L.A. Care is also heavily involved in Los Angeles County's Whole Person Care pilot, a five-year pilot approved under California's Section 1115 Medicaid Waiver Renewal, entitled Medi-Cal 2020. As one of the six target populations within L.A. County's Whole Person Care pilot, individuals experiencing homelessness receive a comprehensive set of services designed to connect them to tenancy support and non-medical intensive case management services that support the Housing First model.

Whole Person Care funding has significantly augmented the Los Angeles County's "Housing for Health" program which launched in 2012 prior to Whole Person Care. In 2016, L.A. Care's Board of Governors approved a five-year, $20 million investment towards the Housing for Health program.[60] Housing for Health provides housing and support services to the county's high utilizers experiencing homelessness. The program contracts with Brilliant Corners, a not-for-profit supportive housing agency, to find supportive housing units for homeless individuals who also receive Intensive Case Management Services (ICMS) to help them retain housing. Individuals are identified through a variety of sources, including ICMS service providers, hospitals, Coordinated Entry System (CES), L.A. Care's internal clinical staff, physician provider groups and community clinics. L.A. Care's $20 million investment will help house 300 individuals experiencing homelessness, 225 of whom will be L.A. Care members. As of April 2018, L.A. Care has successfully housed ten homeless members and received more than 50 further candidate referrals.

Recognizing Los Angeles County's fast-paced housing market, Housing for Health uses several strategies to remain ahead of the curve. Brilliant Corners has biweekly calls with DHS to discuss open cases and the market. In addition, if an available unit opens up, Brilliant Corners can send a check to the landlord the next day to secure the unit. In turn, the landlord stops marketing the unit. "Homelessness is a huge problem in L.A. County, and it's critical that all stakeholders come together to tackle this problem," says L.A. Care CEO John Baackes. "We know that a person's health and well-being starts with stable housing, so we're committed to working closely with Brilliant Corners and the county Department of Health Services to assist the homeless population."[61] The Rand Corporation confirmed that late last year with a study that found there were fewer emergency room visits and hospital stays, and health care costs dropped nearly 60 percent for those in the program."[62] To better coordinate efforts with Housing for Health and Whole Person Care initiatives, L.A. Care hired two full-time staff in the Social Services department who are solely focused on homelessness.

L.A. Care's Safety Net Initiatives department has also trained Member Services staff on alternatives to using members' addresses to verify identity when a member states he or she is homeless. Once the member is identified as experiencing homelessness, the member service representative is trained to triage the call to case management staff so they can be connected to appropriated resources. This small change makes a meaningful difference to members experiencing homelessness: it removes the undue burden of remembering what

address they provided to the state, and allows members to verify their identity using other pieces of information such as their full name and date of birth.

While significant obstacles remain in reducing the gap between housing and health agencies, L.A. Care has made significant strides to help facilitate this divide and can be a leading example of the success of these partnerships. Through the work discussed and new work that will be developed through the Social Determinants of Health Workgroup, L.A. Care is committed to developing innovative solutions to address the needs of their most vulnerable members.

CareOregon

CareOregon is a not-for-profit managed care plan based in Portland, Oregon which serves about 280,000 Medicaid and Medicare members across 28 Oregon counties. Based on a mental health survey conducted at the state level, CareOregon estimates that 17 percent of its Medicaid population is homeless.

CareOregon has created a number of initiatives to help their homeless members. The plan's Health Resilience Program, launched in 2011 and designed by the Population Health Department, is a model for addressing barriers to housing experienced by its highest-risk Medicaid members, one-third of whom face housing instability. Members in the program are paired with specialists who help tackle member issues as they relate to social determinants of health. CareOregon has 30 health resilience specialists across 26 clinics who collectively assist about 2,000 members a year. The specialists help increase primary care visits, reduce avoidable emergency room visits and hospitalization, and direct members to appropriate resources. This has resulted in an annual savings of $1.65 million. Internally, CareOregon employs two full-time designated housing case managers who are charged with finding housing for their homeless members. The plan helps members with moving costs, as well as some rent.
CareOregon has a strong relationship with the Joint Office of Homeless Services. Established in 2016, the agency oversees services that individuals experiencing homelessness receive. The authority has created a pilot project with CareOregon that co-invests resources with a local community based organization to provide mobile Permanent Supportive Housing (PSH) services.

As part of this pilot, CareOregon makes referrals to JOIN, an organization that strives to place homeless individuals into permanent housing. The organization's programs include outreach, housing retention, basic services (e.g., restrooms, showers, a mailing address, laundromat, personal hygiene items), and an immersive education program on the complexities of homelessness. JOIN staff provide short-term stabilization services to individuals placed in housing by CareOregon and offers long-term placement and stabilization to individuals needing PSH.

In 2016, CareOregon was one of six health care organizations to invest into Central City Concern's Housing is Health Initiatives. The plan contributed $4 million of a total investment of $21.5 million to build 382 new housing units across three locations, one of which will also have an integrated health center. Central City Concern not only owns and manages 24 buildings in Portland with over 1,700 apartments, but is also a Federally Qualified Health Center with 11 locations, serving more than 8,000 individuals per year. CareOregon's investment demonstrates its commitment and understanding of the deep interconnection between housing and health. As CareOregon CEO Eric C. Hunter states, "Housing not only improves health outcomes, but helps reduce the overall costs of healthcare. CareOregon's support is an investment in preventive health care and our members' futures."

CareOregon recently invested $150,000 in a transitional housing facility for individuals leaving psychiatric inpatient care. Several key homeless providers are working together to convert a motel into a refuge for up to 22 of these individuals. Currently, 1 in 4 people discharged from Unity Center for Behavioral Health are homeless. These individuals are typically discharged to shelters or the streets, which results in a very high rate of readmissions. The transitional housing facility offers these individuals to have a safe place to recover with supportive services. CareOregon's investment will allow residents to receive two meals a day. Residents will stay one to three months, while they receive help with their medical and physical health, supportive services, life skills and help finding long-term housing.

Finally, CareOregon also attempts to help non-plan homeless individuals gain access to health care services. The plan has an outreach initiative in place where two full-time staff go into the community to shelters, the streets and other places where homeless individuals reside and sign them up for Medicaid. As a result of the Medicaid expansion in Oregon, many more of these individuals are eligible for Medicaid, yet many continue to remain uninsured because they are unaware that they now qualify.

Inland Empire Health Plan (IEHP)

Inland Empire Health Plan (IEHP) is a not-for-profit Medicaid and Medicare managed care plan with 1.2 million Members across Riverside and San Bernardino Counties—a region collectively known as the "Inland Empire." IEHP recently embarked on an endeavor to create a permanent supportive housing program for homeless and unstably housed Members.

IEHP identified approximately 60,000 members at risk of homelessness. Notably, this exercise showed IEHP that ICD-10 codes indicating homelessness are of limited utility and not widely used by providers. Data characterizing these Members (e.g., utilization, medical care costs) were used to develop eligibility criteria for IEHP's housing initiative, which seeks to house homeless Members with high costs and a high degree of acute care utilization.

Acknowledging that they can leverage resources to help these Members, the IEHP Governing Board approved a multi-year initiative to provide access to housing and related support services to three different IEHP homeless populations:

1. Members in custodial care who would prefer to be in community settings and who would be likely to maintain relative independence in such an environment,

2. High-cost, high-utilizing Members who meet the HUD definition of "chronic homelessness" and have conditions that are likely exacerbated by their unstable housing, and

3. High-cost, high-utilizing Members who don't meet the HUD definition of chronically homeless, yet have conditions that are likely exacerbated by unstable housing.

For details on how IEHP is helping Members in custodial care move to community settings, see the 2017 ACAP publication entitled, "Bridging the Health and Housing Crisis." To meet the housing needs of high-cost, high-utilizing Members, IEHP is attempting to leverage existing regional housing programs and systems so as not to duplicate efforts. For instance, IEHP will issue a Master Services Agreement to contract for services with qualified intensive case management service (ICMS) providers to support the plan's homeless population. These organizations will help provide housing related ICMS and closely work with IEHP's staff to develop transition plans, leveraging existing housing programs.

Similarly, IEHP is partnering with existing entities providing property-related tenant services (PRTS) to homeless individuals in the region. These PRTS providers identify low-income housing, assist homeless individuals in negotiating relationships with landlords, and administering flexible funds that may be used for moving expenses and rental subsidies. Over the first two years of the initiative, IEHP hopes to house 200 non-institutionalized homeless Members, half of whom meet the HUD definition of chronically homeless, while the other half may be homeless but do not fit the HUD definition. IEHP's initiative will use the permanent supportive housing model.

IEHP also initiated the formation of a regional flexible housing subsidy pool for the Inland Empire, enabling community stakeholders to make financial contributions that support rental subsidies, affordable housing developments, and improvements to existing properties that will enhance current regional housing programs. In addition, IEHP committed to fund the entire local match ($700,000 for each county) required for the 2017 HUD Notice of Funding Availability Supplemental Funding. This will fund ICMS for 40-60 Members who meet the chronic homeless criteria and will enable the entire HUD grant award to be used for rental subsidies.

To operationalize and coordinate its housing initiative internally, IEHP formed a housing team consisting of clinical and non-clinical staff (e.g., registered nurse, social worker, coordinator) under the direction of a medical director. The housing team receives referrals regarding homeless Members, assesses eligibility and clinical factors, and coordinates hand-offs to ICMS and PRTS partners. Bimonthly case conferences with all relevant stakeholders track progress toward securing housing and support services.

Amida Care

Amida Care is a private, nonprofit community health plan that serves 7,000 Medicaid members in the five boroughs of New York City. Amida Care stands out from the other plans interviewed, first because of its small population and second because of the members it serves: Amida Care is a Medicaid Special Needs Plan (SNP) that provides comprehensive health coverage and coordinated care to individuals with chronic conditions, including HIV/AIDS and behavioral health disorders. The plan serves people living with HIV, people who are experiencing homelessness regardless of their HIV status, and people of transgender experience regardless of their HIV status.

Amida Care believes in whole-person wellness. To ensure care access and retention, Amida Care addresses social determinants of health such as homelessness and housing instability, unemployment, food insecurity, stigma, and discrimination.

The plan's holistic approach to health care focuses on all levels of health: physical, mental, and emotional. Its care coordination model considers the complex medical, behavioral, pharmaceutical, and psychosocial needs of people living with multiple chronic conditions, including HIV/AIDS. To ensure that members receive high-quality care, personalized assistance, and timely services, each member is assigned to an Integrated Care Team (ICT) that works with them to track progress on their Individualized Care Plan and health goals. Eliminating barriers to care, such as food insecurity and unstable housing, creates better connections to primary and behavioral health care, which in turn leads to life-saving health outcomes and significant cost savings:

Amida Care recognizes that housing is health care and looks to address housing as a key component of every individual's plan for a healthier life and a public health cornerstone for achieving undetectable viral loads, which contributes to community health and prevents new HIV transmissions. Approximately 4 percent of Amida Care's members are currently homeless according to the definition of homelessness in the Homeless Emergency Assistance and Rapid Transition to Housing Act (HEARTH Act). The HEARTH Act defines a chronically homeless individual as "a homeless individual with a disability who lives either in a place not meant for human habitation, a safe haven, or in an emergency shelter, or in an institutional care facility if the individual has been living in the facility for fewer than 90 days… ."

Amida Care has developed several programs to address the needs of its homeless members. Once a member has been identified as homeless, this is flagged in Amida Care's database alerting staff about the need to place the member in specific programs and services.

The HOME Program is one of the interventions created by Amida Care. It was created to provide comprehensive and coordinated strategies that facilitate health and psycho-social services for homeless members, leading to appropriate housing opportunities and interventions to address current needs and prevent future homelessness. The HOME team creates member-specific action plans designated to meet the goals and needs of each homeless member. Upon enrollment into the program, members receive the HOME Comprehensive Assessment and are reassessed every 6 months thereafter. The HOME team collaborates with Amida Care's Integrated Care Teams (ICTs) which consist of a Care Coordinator, Health Navigator, Medical Manager, Pharmacy Tech, Case Manager Coordinator, and Health Services Specialist. The ICT meets on a weekly basis to discuss the member's utilization and any physical or behavioral crises that would change the goals and priorities of the member's action plan.

Amida Care partners with community-based organizations that offer specialized supportive housing for individuals coping with mental illness, chronic illnesses such as HIV, and substance use disorders, among other health challenges. Several of the CBOs provide placement services for individuals living with chronic illnesses who are looking for independent housing in the community, need help negotiating with their existing landlords around maintenance concerns, or need assistance accessing eviction prevention services.

Members involved with the criminal justice system have specific barriers regarding denials based on background checks. For individuals who live in New York City, there is Justice-Involved Supportive Housing (JISH). While housed, program participants receive continuous support from a case manager who is able to recommend and connect tenants to crisis interventions, financial management resources, public benefits, substance use counseling and treatment, medication management, and a range of other services for daily living skills. Supportive housing providers include the Fortune Society, CAMBA, and Urban Pathways. Alternatively, Amida Care has relationships with free legal service providers who can assist members with issues involving housing policy and law and provide training to front line staff.

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CHAPTER 6

Conclusion

The impact of inadequate housing on an individual's health is well-documented. We are in an age where housing and health policies can no longer be developed without some linkage between the two. Indeed, most stakeholders—including governments, providers, and health plans—are increasingly considering individuals' health care from a whole-person perspective, taking into consideration the fundamental role social determinants play in health status.

The ten plans interviewed and represented in this paper, as well as the vast majority of Medicaid health plans nationally, have made remarkable strides towards developing local solutions to a national problem.[63] Despite this progress, it is imperative to continuously consider the next steps for Medicaid as it relates to housing. Health plans should and will continue to deploy creative, innovative strategies to meet the health needs of their members, but at what point should federal policy respond with appropriate, standardized incentives? How and when will state and federal governments, plans, and other stakeholders demonstrate the value of addressing chronic homelessness for Medicaid populations? How will housing services be funded? And how will valuable lessons learned by individual health plans be shared nationally?

The challenges discussed resonate across all plans. Data sharing across HUD and HHS agencies will help plans to accurately identify and potentially locate homeless members and develop interventions with appropriate evaluations. Conversely, it will allow housing providers to arrange for Medicaid-reimbursable tenancy support services.[64] Moreover, silos in the health care system itself further exacerbate plans' ability to care for their homeless population with a whole-person care perspective. For instance, many of the plans interviewed had specific components of behavioral health carved out of the plan. Since 30 percent of people experiencing chronic homelessness have a serious mental illness, and two-thirds live with a substance use disorder, the complexity of managing these members across various health providers remains one of the biggest issues.[65]

If HUD and the Center for Medicare and Medicaid Services (CMS) aligned their national policies then perhaps Medicaid could focus on support services, while HUD could shift its funding to providing more rental subsidies.[66] In the absence of a true partnership, these agencies will continue to create policies in a vacuum. Only when all agencies related to individuals' social determinants of health come together to create holistic health policies, will we see the greatest success in tackling the homelessness epidemic.

Notes

63 Ibid

64 Kaiser J. Family Foundation. (2018, March 5). Medicaid Managed Care Plans and Access to Care: Results from the Kaiser Family Foundation 2017 Survey of Medicaid Managed Care Plans. https://www.kff.org/medicaid/report/medicaid-managed-care-plans-and-access-to-care-results-from-the-kaiser-family-foundation-2017-survey-of-medicaid-managed-care-plans/view/footnotes/

65 Clary, A. (2017, January). Federal and State Collaboration to Improve Health Through Housing. National Academy for State Health Policy. http://nashp.org/wp-content/uploads/2017/01/Health-and-Housing-Brief.pdf

66 Substance Abuse and Mental Health Services Administration. (2016). Homelessness and Housing. https://www.samhsa.gov/homelessness-housing

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