

FINANCING EFFECTIVE SERVICES: USING HEALTH SYSTEM RESOURCES TO CONNECT HOMELESS PEOPLE TO HOUSING

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We know what is needed

- Recognize the lasting impacts of trauma on health and behavior
- Protect children from homelessness by helping families with the lowest incomes pay rent
- Make housing available as quickly as possible – and offer people the support they need to get it and keep it
- Focus the most expensive housing and services on people who really need these interventions
 - Use data and assessment tools to prioritize
 - Multi-disciplinary services for health, behavioral health, and support for housing stability
 - Frequent, face to face contact to engage people and motivate change



So how can we pay for it?

How can Medicaid and other resources in health care system pay for the SUPPORT that helps people get and keep housing?

A better use of health care resources

Savings

- Fewer hospitalizations, emergency room visits, stays in detox, residential treatment, or nursing homes
- Savings in other systems – ambulance, shelters and jails

Better care and outcomes

- People are more likely to get recommended care if they are in housing
- Substance use declines even if not a condition of housing
- Reduced mortality

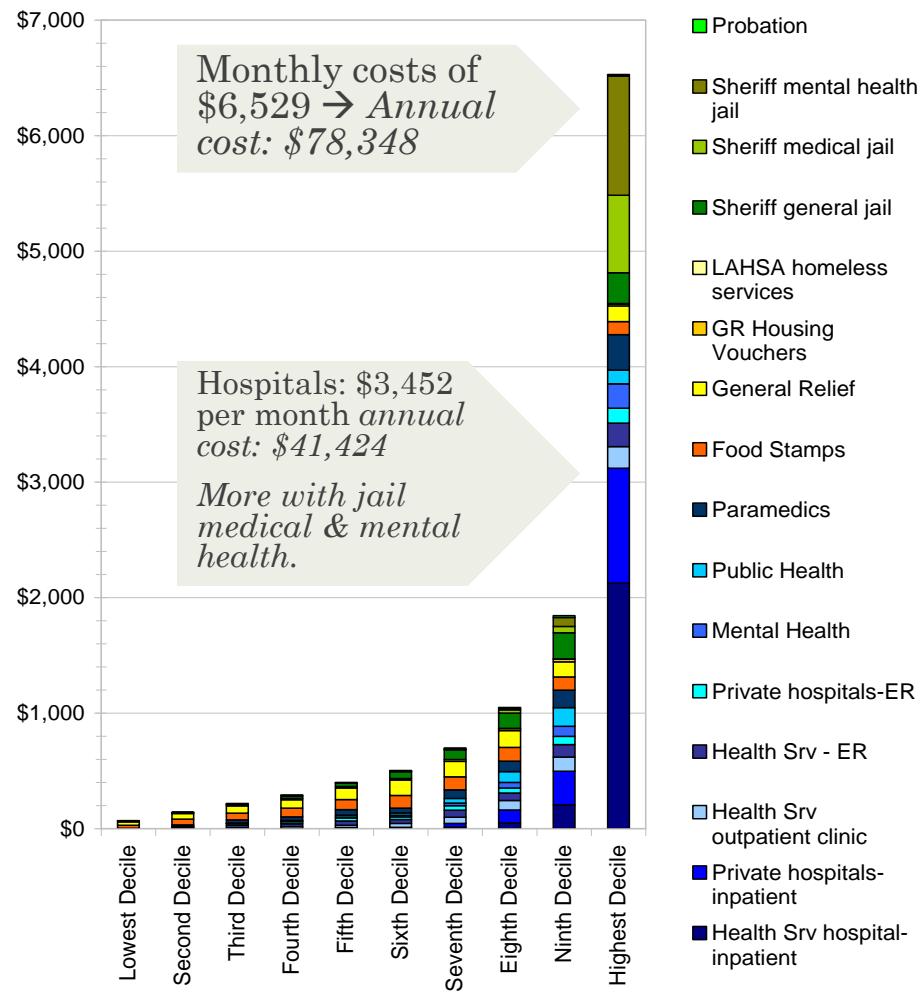
Average Monthly Costs in All Months by Decile for Homeless GR Recipients

Source: 2,907 homeless GR recipients in LA County with Department of Health Services ER or inpatient records.

Reported in:

Crisis Indicator: Triage Tool for Identifying Homeless Adults in Crisis. Economic Roundtable. 2011.

Where We Sleep: Costs when Homeless and Housed in Los Angeles. Economic Roundtable. 2009.





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

Reducing the avoidable costs of homelessness

- Seattle: median per person costs for services used by chronically homeless people with severe alcohol problems
 - \$4,066 per month when homeless
 - \$1,492 after 6 months in housing
 - \$958 after 12 months in housing
- Chicago: homeless hospital patients randomly assigned to housing and case management
 - \$6,307 average annual savings per person compared to usual care. Lower costs for:
 - Hospitalizations (\$6,786)
 - Emergency room visits (\$704)
 - Residential substance use treatment (\$897)
 - Nursing home days (\$895)

Medicaid's role in supportive housing for chronically homeless people

HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE)

- Medicaid and Permanent Supportive Housing for Chronically Homeless Individuals: Emerging Practices from the Field (2014)
- A Primer on Using Medicaid for People Experiencing Chronic Homelessness and Tenants in Permanent Supportive Housing (2014)
- Literature Synthesis and Environmental Scan (2011)
- Four papers published by HHS/ASPE in 2012

Major changes in financing for services

- Expansion of Medicaid eligibility – in some states - to include nearly all homeless people
- State policy decisions about Medicaid benefit design and implementation
- Increasing role of Medicaid managed care
- Changes in health care finance and delivery systems
 - impacts for both chronically homeless people and health care providers who serve them

Medicaid and solutions to homelessness

- Medicaid is a partnership between state and federal government with shared costs
 - States make choices about optional benefits and waiver requests
- Medicaid services can help people get and keep housing
- Some Medicaid services can be provided in supportive housing
- Other Medicaid services can help meet the needs of people who are homeless or supportive housing tenants

Medicaid managed care

- Enrollment in Medicaid managed care is rising
 - People newly eligible for Medicaid
 - Seniors and people with disabilities (SSI)
 - Needs and risks for groups newly enrolled in health plans are very different from children and their parents
- Plan and provider selection
 - Many homeless people are auto-assigned if they do not choose a plan and provider
 - Big implications for clinics and health care providers that serve homeless people – and for partnerships to link services to housing

A mix of payment mechanisms for service providers

- Shifting from paying for volume to paying from value
- Fee for service
 - Usually for encounters or minutes of service
 - Sometimes for a bundle of services (per episode, day, or month)
- Capitation
 - Per member per month payment for a defined set of services
 - Sometimes with financial incentives for controlling utilization & costs (shared risk / savings) and quality
- Grants and contracts for programs
 - May pay for costs not covered by Medicaid reimbursement

Medicaid for services in supportive housing – emerging collaborations with health plans

- Capitation creates incentives for health plans to coordinate care and pay for services that reduce avoidable costs
 - But uncertainty about how spending for new types of services will be reflected in future rate-setting
- 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

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 both Medicaid payment models
- Funding from federal, state, county, local sources is needed to cover what Medicaid doesn't pay for

FQHC services linked to housing

- Satellite clinics in supportive housing buildings
- Clinic located close to supportive / affordable housing
- Home visits to people living in scattered site housing
- Collaborations with mental health service providers to create interdisciplinary teams linked to housing
- Health Care for the Homeless programs can continue to serve homeless people after they move into supportive housing

Challenges and gaps

- Costs for some members of inter-disciplinary teams are not reimbursed in FQHC rates set under federal and state policies
 - Nurses do not provide billable encounters
 - Case management costs may not be included in rates
- Productivity concerns
 - Fewer visits per day when working outside of clinics
- States may limit reimbursement for same-day visits
- Managed care:
 - Difficult to get reimbursed if people enrolled in and assigned to other primary care providers
 - PMPM rates not adjusted to reflect acuity / complexity of needs
 - Provider networks may not facilitate continuity of care
- Some FQHCs do not adapt service delivery approach to meet needs of people experiencing chronic homelessness
 - May have limited capacity for serving people with serious mental health or substance use disorders

Financing for mental health services

- Optional Medicaid benefits can cover mental health services delivered in a range of community settings
 - With supervision by clinicians, services can be delivered by peers, workers with other skills and training
 - Rehabilitative services
 - Targeted case management
 - Home and community-based services
- Effective service strategies support recovery by doing “whatever it takes”
 - Flexible funding from grants, states, or local government pays for services not covered by Medicaid

Community Support Teams and ACT covered by Medicaid in some states

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

Challenges and gaps

- Fragmented and inconsistent approaches to covering services for medical, mental health, and substance use disorders
 - In most states Medicaid benefits cover limited array of services to address substance use – only in approved settings, making it hard to deliver integrated services for co-occurring disorders
- Covered mental health services and goals usually must be related to diagnosis, symptoms and impairments related to mental illness – not (directly) related to substance use problems or other health needs
- Provider requirements often not designed for mobile, team-based models of service or shared electronic records
- These are state policy decisions – not federal requirements

Challenges and gaps (continued)

- Federal rules make distinction between “rehabilitative” and “habilitative” services
 - Skills people need to get and keep housing may not be covered
- As people recover, they may lose eligibility for ongoing support from intensive mental health service models
 - Other less intensive services may not be mobile with capacity to do “whatever it takes”
 - It can be hard to return to more intensive services during a crisis that could lead to losing housing
 - Responsibility for mental health services may shift to managed care plans
 - Changes may disrupt trusting relationships

What's working?

- Outreach teams can assess homeless people who are not engaged in the mental health system and determine eligibility for services
- States and counties understand mobile, team models and provide training for Medicaid reimbursement with focus on services in supportive housing and other settings outside of clinics
- Partnerships use flexible funding to create integrated teams linking behavioral health and primary care services
- Mental health providers help consumers navigate managed care enrollment, provider selection, access to care
- Medicaid managed care plans contract with behavioral health providers for risk assessment and care management

Some counties with public hospitals are investing in supportive housing as health care

- Housing for most vulnerable and high cost homeless people reduces avoidable hospital costs and improves health
 - Evidence of savings justifies health system investment
- Hennepin Health funds housing navigators
 - Facilitate housing referrals for patients with high costs and/or health conditions impacted by homelessness
- Los Angeles DHS Housing for Health program
 - County health department pays nonprofit partners for case management and housing-related services
 - Linked to housing developed with city funding and vouchers administered by housing authorities
 - Public-private partnership funds Flexible Housing Subsidy Pool
 - Permanent and interim / respite housing options

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

- Home and community-based services (HCBS) for people with disabilities
 - Medicaid can pay for housing locators and other housing-related services and supports
- 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
 - More than a medical home

What changes are needed to finance what works?

- Payment mechanisms and rules create incentives (and remove obstacles) for teams that integrate care for health, mental health and substance use needs
- Medicaid coverage for services in settings outside treatment programs to address harmful substance use, and motivate people to make changes to reduce risks
- Payments to health plans and providers are adjusted to reflect risk and complexity of consumer needs
 - Taking social determinants of health into consideration
 - Allowing reinvestment of savings to pay for services that help reduce avoidable costs
- For vulnerable people with complex needs, services to support housing stability are recognized as essential part of health care and care coordination
 - Cost are incorporated into rate-setting

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