

# 1115 MEDICAID WAIVER: HOUSING WORK GROUP

## POTENTIAL CONCEPTS

The State should recognize the importance of housing stability to health stability. Evidence shows helping individuals experiencing chronically homelessness find permanent housing, and helping formerly homeless individuals maintain stable housing dramatically improves health outcomes, while dramatically decreasing inpatient and nursing facility costs. Similarly, helping nursing facility residents find permanent housing achieves *Olmstead* goals of promoting independence among beneficiaries and radically reduces costs. Multiple studies show supportive housing—housing affordable to people living in extreme poverty, without limit on length of stay, and with case management services offered to support housing stability—decreases the costs Medicaid incurs.

### Eligible Populations

California could propose changes to Medi-Cal to address the health needs of both high-cost homeless populations, for whom changes to Medi-Cal would improve health outcomes and decrease costs, and nursing home residents who could live independently. Based on data demonstrating risk of frequent institutional or acute care use, the following populations would be eligible:

Nursing Facility Residents	No identified need to remain in nursing facility, and	
	An extended stay	Not admitted solely for purposes of rehabilitation and
		No discharge plan
High-Cost Homeless Beneficiaries	Beneficiaries with a <u>combination</u> of chronic medical, mental health, and/or substance use disorders, and who have severe functional limitations, defined as—	
		Meeting the HUD definition of chronic homelessness,
		Residents of permanent supportive housing who met the HUD definition of chronic homelessness when moving into housing,
		Meeting the HUD definition of homelessness and— <ul style="list-style-type: none"> <li>• Have incurred 5 or more visits to the emergency department over the last 12 months or 8 or more visits over the previous 24 months</li> <li>• Have incurred at least 3 inpatient admissions within 12 months, at least 45 days inpatient (cumulative or single) in 12 months, or at least 5 admissions within 24 months</li> </ul> OR
Experiencing periods of homelessness and institutionalization, including inpatient hospitalization, institutes of mental disease, or incarceration, of at least 30 days over the previous 24 months.		

# Incentives to Health Plans to Fund Non-Traditional Services to Achieve Health Stability

## Services:

The State would authorize health plans flexibility to use a portion of capitation payments contingent on approval from the Centers for Medicare and Medicaid Services to pay for services that are not traditionally defined as covered Medicaid State Plan services, if these services allow beneficiaries to achieve and maintain health stability. Specifically, health plans could use a portion of capitation payments to pay a case rate for housing-based case management services for eligible populations. For purposes of rate-setting, these costs would be recognized as Medicaid-reimbursable services. To include as an allowable costs, health plans would contract with qualified service providers. Qualifications for service providers should include experience specializing in addressing the needs of the populations identified and ability to move people into housing within three months. The State would continue to allow plans flexibility in contracting, including authority to contract with providers who may not be current Medi-Cal providers.

Additionally, the State would allow health plans to use a portion of capitation payments to fund contributions to the Integrated Care Savings Pool to fund housing-based case management services.

The State would define “housing-based case management services” as pre-tenancy supports, tenancy supports and care coordination.

- Pre-tenancy supports:
  - Outreach to locate and reach out to beneficiaries
  - Engage beneficiaries to want to participate in services
  - Housing search assistance
  - Collecting documents to apply for housing & benefits
  - Helping beneficiaries with applications & recertifications
  - Advocacy & negotiation with landlords
  - Moving assistance
- Tenancy supports:
  - Eviction prevention
  - Crisis intervention
  - Motivational interviewing
  - Trauma-informed care
- Care coordination services:
  - Creating a care plan incorporating social determinants of health (including housing)
  - Coordination of care between primary care, behavioral health care, and social services
  - Discharge planning
  - Transportation to appointments
  - Patient advocacy

Services could also include services provided in unlicensed recuperative care, including—

- Services of a nurse case manager, and
- Services of a housing navigator to engage beneficiaries, provide housing search assistance, collect documents to help patients apply for housing, and assist beneficiaries with applications.

Services must—

- Be delivered where the beneficiary lives,
- Promote housing retention
- Be voluntary,
- Involve face-to-face and frequent interactions with the beneficiaries, with low case manager-to-client ratios, and
- Include outreach to locate eligible beneficiaries and engagement to form trusting relationships.

The State should also include in a Waiver proposal mention that the State intends to submit to CMS a State Plan Amendment to take advantage of the option included in Section 2703 of the Affordable Care Act, to create Health Homes for Enrollees with Chronic Conditions. The State's State Plan Amendment would provide health home services to beneficiaries with a combination of conditions who are experiencing chronic homelessness or frequently use hospitals for avoidable reasons, a population very similar to the criteria identified above.

The flexibility included in this Waiver would assist health plans in building capacity to contract with health home providers and build health home capacity. Health plans could also use their capitated rates without rebasing of rates to fund services health homes do not fund, or in counties where health homes are unavailable.

### **Housing:**

Contingent on CMS approval, The State would authorize health plans flexibility in identifying contributions from savings the plans realize, based on costs among beneficiaries stably housed, to the Integrated Care Savings Pool, as further described below. The State would then recognize these contributions as allowable costs. The Savings Pool would then be used to fund rental subsidies, housing-based case management services, and recuperative care for eligible populations. To include these contributions as allowable costs, health plan contributions would include only contributions for the number of eligible members who benefit from the Savings Pool. Alternatively, the State would allow health plans to fund housing costs as allowable costs for eligible populations.

Any housing the plans or the Pool funds must meet regulations defining housing as “community-based” under CMS “Home and Community-Based Services” regulations. Regional Integrated Care Partnerships must identify potential housing funders as partners to use existing housing funds, and to prevent gaps in rental assistance over the long term.

## **Incentives to Plans, Counties & Providers to Create Regional Partnerships & Recuperative Care**

### **Regional Integrated Care Partnerships:**

The State would provide incentive payments to health plans and counties to create regional integrated care partnerships among health plans, county behavioral health plans, hospitals, and housing and social service providers. Health plans and counties could receive incentives based on achieving the following:

- Creating data sharing systems across at least two systems (i.e., Homeless Management Information System and county hospital or health plan data);
- Developing memoranda of understanding or contracts between plans, hospitals, county housing agencies, housing authorities, county mental health and drug treatment programs, non-profit housing providers, homeless service providers, California Community Transitions providers, or other partners attempting to move beneficiaries out of homelessness, hospitals, and nursing facilities into independent, permanent supportive housing;
- Moving at least 50 beneficiaries meeting eligibility criteria into permanent supportive housing through partnerships with housing providers and contributions to an integrated care savings pool; and
- Forming an integrated care savings pool (described later).

To receive approval for incentive payments, a health plan and/or county would provide the State with a strategy to achieve the goals listed above. If approved, once the plans/counties achieve at least the first two of the above, the plans/counties would be eligible for payment. A partnership would be a stronger applicant if achieving the entire list, and could receive additional incentives at future periods if meeting the metric of moving additional beneficiaries into permanent housing over the five years of the Waiver period. The partnership should be evaluated based on defined state outcomes for improving care to patients and achieving other state identified goals.

Incentives could include allowing health plans to include costs of creating partnerships in their allowable costs, increasing health plan administrative costs, payments to public hospital counties, or payments to providers.

Incentives would vary according to how many of the above commitments to achieving a state-approved strategy through the regional pilot, and the number of beneficiaries moved into stable housing. Up to 10 regional partnerships would be eligible for incentives, and the State would determine eligibility based on the strength of the partnership and capacity of providers to address housing needs of beneficiaries. The State would encourage more than one health plan (if in geographic managed care counties or two-plan counties) participate in the partnership to avoid complications of churning of members from one plan to another. The State could also favor counties already using county health care dollars to fund services or rental subsidies in supportive housing for high-cost homeless patients.

### **Establishing Recuperative Care:**

Because homeless beneficiaries incur more frequent and longer hospital stays than housed beneficiaries, and because residents of nursing facilities have high rates of hospital readmission, the State recognizes

recuperative care as critical in reducing hospital readmission. Recuperative care offers nurse care to hospital patients who no longer need inpatient care, but are too ill to return to homelessness, or would otherwise be referred back to nursing facilities. The State would recognize that recuperative care is not effective in reducing hospital readmissions over the long term if not paired with housing navigation services. These services identify available housing opportunities for patients once discharged, assist residents in completing housing and voucher applications, and helping beneficiaries move into permanent housing. Hospital staff, working with recuperative care facilities, would refer eligible beneficiaries to recuperative care.

The State would offer provider incentives for up to 10 regional integrated care partnerships to move at least 50 eligible beneficiaries annually each into recuperative care programs. Programs could be created using existing shelter, hospital, or transitional housing beds, and staff programs with nurse care managers and housing navigators.

### **Non-Federal Costs:**

The State and counties would share the State's share of costs of provider incentive payments:

- If the partnership's focus is housing beneficiaries who currently reside in nursing facilities, the State would bear the non-federal share of costs.
- If the partnership is created to house beneficiaries who are high cost homeless beneficiaries, the county would bear the State's share of costs.
- Counties could use Mental Health Services Act funds, including Mental Health Services Act (Proposition 63) Full-Service Partnership funds, used to pay for services and rental subsidies, to provide all or a portion of the non-federal share of costs (to the extent these funds are not already used as match for other Medicaid reimbursed services) if beneficiaries stably housed are eligible for and receive assistance through MHSA.

## **Integrated Care Savings Pool**

### **Based on Regional Partnerships:**

In addition to providing county funding for the non-federal share of funds used to make the incentive payments (described above), the State would encourage Regional Integrated Care Partnerships to establish an Integrated Care Savings Pool. Health plans and counties may contribute to the Pool, along with other local funders who wish to contribute, in amounts necessary for eligible beneficiaries to obtain and maintain housing stability through housing-based case management services (if not offered through health homes, incentives to health plans, or county-based payment), rental subsidies, and/or recuperative care interventions. The Pool would fund a menu of options:

- Payments to permanent supportive housing providers or housing intermediaries to keep beneficiaries stably housed,
- Payments to recuperative care facilities for operating costs, nurse care managers, and housing navigators; and
- Payments to community-based organizations providing services described above, if services not otherwise funded through health homes, incentives to health plans, or county-provided payment.

Health plans and counties could contribute amounts necessary to achieve projected cost savings from moving people into supportive housing. For example, a regional partnership could project decreased inpatient costs of 25-35% per eligible beneficiary, and contribute to the Pool amounts necessary to achieve those savings, up to a maximum contribution the State designates. These contributions would be considered allowable costs for health plans.

In exchange for contributions to the Pool, health plans would designate a number of their members who would receive assistance. Similarly, counties contributing to the Pool could designate a number of their hospital or medical home patients to benefit from the Pool.

Other funders may contribute to the Integrated Care Savings Pool.

Contributing health plans, counties, and other funders would oversee administration of the Pool, and make decisions about Pool expenditures. To receive incentive payments for the costs of creating a Pool, however, plans/counties must contract with a non-profit housing provider or housing intermediary, with experience locating potential housing opportunities and partnering with affordable housing providers, to administer housing funds and services funds.

### **Creating a State Pool:**

Instead of regional partnerships, the State could monitor total reductions in costs among eligible beneficiaries residing in designated counties, based on an independent evaluation that takes into consideration differences in primary, specialty, and inpatient costs. Health plans would voluntarily contribute these savings and these contributions would be allowable costs, or the State would recalculate rates and contribute a portion of the savings (amounts needed to fund the intervention producing the savings) to the pool. Using the savings, the State would provide funding for housing-based case management services through the Department of Health Care Services to counties and community-based organizations, and for rental subsidies through the Department of Housing and Community Development or the California Housing Finance Agency.

## **County-Funded Services**

An alternative option to incentives to health plans in funding housing-based case management services is for counties to administer housing-based case management services. Counties would fund the state match of the costs, and contract with community-based organizations to provide the services. Counties would have flexibility to contract with non-traditional providers, including unlicensed paraprofessionals, through a case rate providers could use to offer a range of services, depending on the beneficiary's needs. Counties would be able to designate behavioral health or health departments to administer. Counties could pair existing county general funds or Mental Health Services Act funds not otherwise matchable through Medicaid. The Department of Health Care Services would then distribute to the counties the State's share of savings from recalculations in health plan rates.

## **Budget Neutrality**

A substantial and growing body of evidence demonstrates stable housing for eligible high-cost homeless populations can significantly improve treatment compliance, reduce the need for institutionalization, and reduce overall costs. The State would expect decreases in costs of care well beyond the costs of incentives and health plan expenditures:

- Medi-Cal beneficiaries participating in foundation-funded frequent user programs reduced Medi-Cal hospital costs by \$3,841 per beneficiary after one year and \$7,519 per beneficiary per year after two years over and above the costs of these programs.<sup>1</sup>
- A Washington study showed homeless chronic inebriates connected to intensive case management incurred \$2,449 less in Medicaid costs per person, *per month* than control group participants after six months, beyond the costs of the program.<sup>2</sup>
- Two randomized studies of chronically homeless people receiving supportive housing showed participants decreased hospital days by a third within a year and 46% after 18 months, and decreased nursing home days by over 60% within a year compared to groups getting usual care.<sup>3</sup>
- The Massachusetts Office of Medicaid reported decreased costs of over \$17,500 per member, per year, from a state program offering comprehensive case management in housing.<sup>4</sup>

Among nursing facility residents, Department of Health Care Services' estimates indicate cost reductions of almost 60% in moving beneficiaries from skilled nursing facilities to community-based settings.

Skilled Nursing Resident Costs		Home and Community-Based Resident Costs	
Annual Cost	\$65,739	Annual Cost	\$26,653

<sup>1</sup> Linkins, *supra*. The calculated costs avoided are based on average reductions in ED visits and inpatient days for Medi-Cal patients at rates the Office of Statewide Health Planning and Development (OSHPD) reported as costs for hospitals connected to frequent user programs. Rates averaged \$305 per ED visit and \$2,161 per inpatient day. OSHPD 2006 data. [www.OSHPD.gov](http://www.OSHPD.gov).

<sup>2</sup> Mary Larimer, Daniel Malone. "Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problems." *Journal Am. Medical Assoc.* 2009; 301(13):1349-1357 (2009).

<sup>3</sup> David Buchanon, Romina Kee. "The Health Impact of Supportive Housing for HIV-Positive Homeless Patients: A Randomized Controlled Trial." *Journal Am. Medical Assoc.* (June. 2009) 99;6; David Buchanan, Romina Kee, Lisa Sadowski, et. al. "Effect of a Housing & Case Management Program on Emergency Department visits and Hospitalizations Among Chronically Ill Homeless Adults: A Randomized Controlled Trial." *Am. Journal Public Health.* (May 2009) 301;17.

<sup>4</sup> Massachusetts Housing & Shelter Alliance. Home & Healthy for Good: Progress Report. Mar. 2012.