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Improving Care for Medicaid Beneficiaries Experiencing Homelessness: Emerging Best Practices and Recommendations for State Purchasers

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Introduction

Nationwide on a given night in January 2014, more than 578,000 people were homeless, and one third of these people were sleeping on the streets, in cars, or other places not meant for human habitation.¹ Over the course of a year, about 1.42 million people used a shelter or transitional housing program for homeless individuals or families.² Homeless people often have significant health and behavioral health needs that can be very difficult to manage without stable housing. Compared to the general U.S. population, adults who are homeless as individuals, or in families with children, are more than twice as likely to have a disability.³ Older homeless adults often have chronic and disabling health conditions that put them at risk of extended stays in hospitals and nursing homes. People who are chronically homeless often have complex, co-occurring physical disabilities, chronic medical conditions, serious mental illness, significant cognitive impairments, and/or substance use disorders.

Many people who experience homelessness are Medicaid beneficiaries. In states that have expanded Medicaid eligibility as an option under the Affordable Care Act, nearly all adults experiencing homelessness are eligible for Medicaid. In addition, an increasing number of homeless Medicaid beneficiaries are enrolled in managed care plans and other organized delivery systems. Medicaid agencies and their managed care contractors have important roles to play in purchasing health care for people who experience homelessness and improving outcomes for these vulnerable beneficiaries. Costs for hospitalizations, emergency room visits, crisis behavioral health treatment, and long term care place some homeless adults among “super-utilizers,” a small group of beneficiaries whose health care accounts for the largest share of Medicaid costs.

To respond effectively to homeless persons’ needs for health care, behavioral health, care management, and health-related support services, new strategies are needed, including interventions that help Medicaid beneficiaries obtain and maintain housing. There is a growing body of evidence showing that supportive services and related housing interventions can help achieve significant savings by reducing avoidable emergency room visits, hospitalizations, readmissions, and other health care costs – particularly when the assistance is targeted to the most high-cost and highly vulnerable Medicaid beneficiaries experiencing homelessness.⁴ In this context, the Centers for Medicare and Medicaid Services (CMS) recently issued an Informational Bulletin which highlights opportunities for states to use Medicaid to pay for housing-related activities and services that expand home and community-based living opportunities for individuals with disabilities.⁵ CMS and the Substance

ABOUT STATE HEALTH AND VALUE STRATEGIES

State Health and Value Strategies, a program funded by the Robert Wood Johnson Foundation, provides technical assistance to support state efforts to enhance the value of health care by improving population health and reforming the delivery of health care services. The program is directed by Heather Howard at the Woodrow Wilson School of Public and International Affairs at Princeton University. For more informations, visit statenetwork.org.

ABOUT THE ROBERT WOOD JOHNSON FOUNDATION

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Carol Wilkins, MPP is a nationally recognized expert on integrating health care, social services, and housing assistance for persons with disabilities, with a focus on persons who experience homelessness. She conducts research and provides technical assistance to develop and support the implementation of evidence-based policy solutions for people with complex health needs and vulnerabilities. She has worked with several states to support the use of Medicaid financing and delivery systems to provide the services and supports needed for homeless people with complex health needs to get and keep housing, and to reduce avoidable hospitalizations and other costs.

Abuse and Mental Health Services Administration (SAMHSA) are working on providing additional guidance regarding Medicaid reimbursement for housing-related activities and services for persons experiencing chronic homelessness.

With support from the Robert Wood Johnson Foundation's State Health and Value Strategies (SHVS) program, in 2014, California's Department of Health Care Services (DHCS) sought ways to identify and improve care for Medi-Cal members with complex health needs experiencing or at high risk of homelessness. DHCS obtained expert technical assistance from Carol Wilkins, the author of this issue brief and an independent consultant expert in housing issues. Ms. Wilkins facilitated webinars and meetings with DHCS staff and the medical directors of contracted Medicaid managed care organizations (MCOs) to share information about housing resources and emerging practices for improving care and achieving savings by linking more Medicaid beneficiaries with permanent supportive housing. SHVS resource materials developed for California have been adapted for a national audience and included as handouts accompanying this brief. State agencies can use these handouts for discussion and training with Medicaid staff, MCOs, providers and other stakeholders.

This brief and the handouts provide information for state purchasers, Medicaid plans and providers interested in answering the following questions:

1. What is Permanent Supportive Housing (PSH) and Why is it Important?
2. How Can State Medicaid Agencies and MCOs Identify and Characterize Local Housing Resources and Other Assistance for Beneficiaries Who Are Homeless?
3. Which Data Help Identify Individuals Needing Stable Housing and Where Do States and MCOs Obtain Such Data?
4. Since Housing Resources Are Limited, How Should State Agencies and MCOs Prioritize Which Medicaid Members Are Directed to These resources?
5. What Innovations Have Medicaid MCOs and Providers Implemented to Control Costs and Improve Care for Homeless Members?
6. What Purchasing Strategies Can States Pursue to Encourage Innovation by MCOs and Providers to Achieve Shared Goals for Beneficiaries Experiencing Homelessness?
7. What Medicaid Policy and Coverage Changes Can States Pursue to Improve Health Outcomes and Reduce Costs for Beneficiaries Experiencing Homelessness?

1. What is Permanent Supportive Housing (PSH) and Why is it Important?

PSH combines affordable rental housing with supportive services needed to help the most vulnerable and disabled homeless people obtain and maintain housing. Case management and other services that support housing stability are individualized and facilitate an individual's access to appropriate care, help people to manage chronic and disabling health conditions and symptoms of mental illness, increase skills for community living, and reduce harmful substance use and social isolation. Key components of supportive services effective in linking homeless people with complex health needs to care and maintaining housing stability include:

- face-to-face case management and care management services,
- visits in home and community settings, outside of clinics or treatment facilities,
- integrated attention to medical, behavioral health, and social needs using multi-disciplinary teams and "warm handoffs" between service providers,
- a trauma-informed approach to engagement and building trust with people who have often not been effectively engaged in appropriate care and treatment,
- sustained relationships that facilitate continuity of care, and
- motivational interviewing and strategies that recognize stages of change while working to reduce harms related to substance use and other health risks.

Handout #1: Permanent Supportive Housing provides basic information about supportive housing, how it works, and for whom it is most appropriate. The handout includes some of the same information from this brief in a format that states can print out and use during discussions with contracted MCOs and other stakeholders. **Handout #1** also offers tips for states and MCOs to help connect Medicaid beneficiaries to local supportive housing and homeless assistance programs and to collaborate with these programs to better serve beneficiaries who have complex needs.

Outcomes for at-risk individuals that obtain PSH services include high rates of housing stability, connections to more appropriate care, and reductions in hospitalizations,

emergency room visits, nursing home stays, and other health costs.⁶ Significant health care cost savings may be achieved when Medicaid beneficiaries move from homelessness into PSH.⁷ In Chicago, for example, annual health care costs were \$6,300 lower for homeless persons with chronic illnesses enrolled in a program offering supportive housing, compared to similar persons randomly assigned to “usual care” upon discharge from the hospital.⁸

Too often, leaders in state Medicaid agencies, health plans, and providers are not familiar with the local homeless assistance and housing systems and not prepared to make the connections that would facilitate access to supportive housing for Medicaid beneficiaries.⁹ Similarly, many providers of housing and services for homeless people are not well connected to Medicaid agencies or managed care delivery systems.

2. How Can State Medicaid Agencies and MCOs Identify and Characterize Local Shelter and Housing Resources?

Handout #2: Understanding the Homeless Assistance System is designed to help Medicaid agencies, MCOs, and providers better understand the local systems and programs available to assist Medicaid beneficiaries experiencing homelessness. Most leaders and staff who work in Medicaid agencies, MCOs, organized delivery systems, and provider organizations have a limited understanding of homelessness, and they are often unfamiliar with local housing resources and promising practices that can link Medicaid services with housing resources. As a result, even when purchasers, plans and providers learn about PSH, they often do not know where to call or how to make connections at the local level to facilitate access to housing for highly vulnerable Medicaid beneficiaries.

There are many different supportive housing and homeless assistance programs. Available housing and homeless assistance programs vary from one state or region to another. A Continuum of Care (CoC) is a regional or local planning body that coordinates housing programs and other assistance for people who experience homelessness with federal funding from the U.S. Department of Housing and Urban Development (HUD). Most states have more than one CoC, but a few states have a single statewide CoC. Each CoC is responsible for developing a community plan to meet the needs of people who are homeless. In January 2015, HUD announced \$1.8 billion in grant funding for CoC homeless assistance programs, including \$45 million for new PSH to serve homeless people with disabilities. **Handout #2** includes tips for finding local CoCs and information on housing resources, including an inventory of permanent

supportive housing, emergency shelters and transitional housing programs that serve homeless people.

State Medicaid agencies should refer to information in the first two handouts to help them utilize the sample and template provided in **Handout #3 Helping Homeless Medicaid Beneficiaries in [insert state/county/region]**. The template for **Handout #3** suggests approaches for states and other stakeholders interested in developing a local housing resource summary similar to the sample handout developed for Santa Clara County in California.

3. Which Data Help Identify Individuals Needing Stable Housing and Where Do States and MCOs Obtain Such Data?

Identification of homeless beneficiaries may require states and plans to compare multiple data sources, such as addresses included in Medicaid enrollment and encounter data. To the extent feasible, Medicaid agencies should obtain information about an applicant’s homelessness as part Medicaid application process, and share this information with MCOs. States can use and share **Handout #4: Screening to Identify Beneficiaries Experiencing or At Risk of Homelessness** to more effectively identify these vulnerable Medicaid beneficiaries with special needs. For example, people experiencing homelessness often use as their mailing address the shelter, clinic, or social services agency where they submit Medicaid applications or receive cash assistance. In addition, hospitals and other providers may use a special zip code in patient addresses to indicate the person receiving care is homeless. **Handout #4** provides some specific examples being used in some areas or by some facilities. Medicaid agencies, MCOs, and providers should compile and utilize these sorts of address markers in enrollment and encounter data to routinely identify homeless beneficiaries.

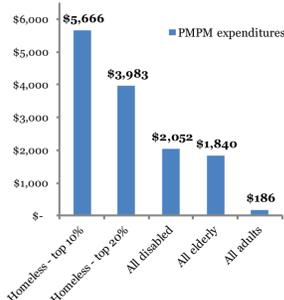
States, MCOs, and providers can improve the identification of homeless beneficiaries by regularly matching Medicaid enrollment or claims data with other sources, such as data in a local or statewide Homeless Management Information System (HMIS). The state of Washington has created an integrated client database with longitudinal data from more than 30 data systems.¹⁰ This database includes an indicator of homelessness that uses data from multiple information systems, including HMIS, eligibility data, and medical billing records.¹¹ In Texas, for example, the United Healthcare Community Plan, a Medicaid MCO, works with the local homeless coalitions in Houston and Austin in a new pilot program to match data in the HMIS with health plan data. The data match identifies members who are experiencing homelessness and frequently using hospital care or emergency medical services.

States Medicaid agencies and their partners face challenges, however, related to the completeness, accuracy, and timeliness of data sources to identify vulnerable Medicaid beneficiaries with unstable housing. Some experts on the connections between housing and health suggest that housing status is a “vital sign” which should be integrated into health risk assessments and other routine screening when vulnerable patients come in contact with health care providers.

A few relatively simple questions about where people are living now, where they have been living, or how often they have moved, help identify Medicaid beneficiaries who are currently homeless, as well as those at high risk of becoming homeless. As noted in the accompanying handout related to screening beneficiaries at risk of homelessness, the Veteran’s Administration (VA) has begun to implement routine screening for all veterans who receive outpatient care at VA medical facilities. The VA’s simple screening tool is included at the end of [Handout #4](#) and can be adapted by plans, hospitals, and others to help identify persons who are homeless or imminently at risk of becoming homeless.

Connecticut Medicaid-HMIS Data Match

- HMIS data set consisting of 8,132 clients sent to Medicaid Department
- 4,193 single adult Medicaid beneficiaries identified as homeless in Medicaid in 2012
- Among matched, top 10% (n=419) used \$28.5 mil in Medicaid service costs in 2011 (\$5,666 PMPM)



4. Since Housing Resources Are Limited, How Should State Agencies and MCOs Prioritize Which Medicaid Members Are Directed to These Resources?

States and MCOs often use algorithms to stratify their patient population by risks that can be identified or predicted using Medicaid claims data. These algorithms usually rely on information regarding diagnoses, pharmacy claims, and hospitalizations or emergency room visits, but rarely include indicators of homelessness or other factors that can greatly impact risks and health care costs. States should encourage or require MCOs to explore additional data sources, screening tools, and predictive modeling algorithms to incorporate best practices and more effectively target resources to high-cost or high-risk Medicaid members experiencing homelessness.

A growing number of communities are using screening tools or algorithms that assess vulnerability and risk among homeless people to prioritize access to housing assistance for

those with the greatest needs. In addition to health care data, these predictive modeling tools often incorporate additional information from screening tools that use self-reported information about arrests and incarceration, stays in emergency shelter or unsheltered locations, and victimization. In some places, cross-sector integrated data systems can be used to verify self-reported information about service utilization.

By using and sharing data to identify homeless beneficiaries and their characteristics and patterns of service utilization and costs, Medicaid agencies, MCOs, and their partners can create a data-informed dialogue with other funders and stakeholders in the housing and homeless assistance system to improve outcomes and achieve savings.

In **Connecticut**, the state matched Medicaid claims data to HMIS data provided by the Connecticut Coalition to End Homelessness to identify a population of 4,193 single adult Medicaid beneficiaries identified as homeless in 2012.¹² Average annual Medicaid service costs were nearly \$68,000 for the top ten percent of these homeless beneficiaries and accounted for over \$28.5 million in total Medicaid expenditures in one year. This Connecticut data helped to inform the design of a health home outreach model that links high-cost, high-need beneficiaries with multidisciplinary health care and supportive housing.¹³

Federal guidance strongly encourages grantees that receive funding through HUD’s Continuum of Care (CoC) homeless programs to establish policies that prioritize the most vulnerable and chronically homeless people for available housing using a coordinated assessment and standardized assessment tool or process.¹⁴ The Vulnerability Index & Service Prioritization Tool (VI-SPDAT) is a standardized triage tool used in many communities and referenced in [Handout #4](#).¹⁵ In states where the Medicaid program has established criteria to identify high-cost, high-need beneficiaries, CoC program-funded permanent supportive housing may use the same criteria to identify homeless persons with severe service needs, and prioritize these individuals for housing assistance that can be coordinated with Medicaid services. However, this determination must not be based on a specific diagnosis or disability type.

States can learn from promising initiatives that have often been launched by local leaders and innovative Medicaid providers and MCOs. Many supportive housing providers have collaborated with Medicaid providers to deliver housing assistance linked to supportive services for the most vulnerable homeless adults, including those who are frequent users of hospital emergency room and inpatient care. Leaders in local homeless assistance systems are creating new coordinated

entry systems to prioritize the most vulnerable and chronically homeless people for housing assistance, using screening tools and other criteria that can make housing assistance more readily available to high-cost Medicaid beneficiaries with complex health needs. These efforts are often launched with initial support from foundations, local governments, and time-limited federal grants. As these programs demonstrate results, providers and their local partners often ask state Medicaid agencies to adapt their policies and purchasing strategies to provide the support needed to sustain and expand effective program models.

In **California**, 14 Los Angeles hospitals are involved in partnerships with homeless service providers and community health centers to identify and serve homeless patients among the most frequent users of hospital services. The hospitals and their partners use a screening tool that identifies homeless people whose characteristics make them likely to be among the top 10 percent in costs for hospitalizations and other public services.¹⁶ Case managers employed by community organizations work to connect these individuals with a medical home, emergency and permanent housing, behavioral health services, and other supports as needed. These partnerships were initially funded by foundations, federal grants, and hospital contributions, and are now receiving some support from Medicaid managed care organizations (MCOs). California has requested federal approval for a waiver proposal that would make it easier for MCOs and counties to use Medicaid to pay for these services in the future.

In **Minnesota**, Medica, a Medicaid MCO, is partnering with Hearth Connection, a non-profit organization that manages funding for scattered site PSH. Medica identifies high-risk homeless members who have significant health risks and those who are frequent users of crisis health services or hospital care. Hearth Connection and its partners provide the services that help to engage these homeless members, connect them to housing, and deliver the ongoing support services that help members keep their housing, get connected to appropriate health services, and improve health outcomes. The health plan pays a monthly per-person fee to Hearth Connection to pay providers to find and engage the member and deliver ongoing support. Existing Medicaid benefits managed by the health plan pay for community behavioral health and targeted case management services, and Hearth Connection uses federal grant funds pay for housing assistance.

5. What Innovations Have Medicaid MCOs and Providers Implemented to Control Costs and Improve Care for Homeless Members?

Some Medicaid plans are contracting with providers of behavioral health services, including organizations that deliver services to people living in PSH, to deliver care management services. These behavioral health service providers often have established relationships with some members as well as capacity to make home visits. With support from MCOs, behavioral health workers, including multi-disciplinary teams and supportive housing service providers, can integrate care management services with other services they deliver, helping to educate consumers about management of chronic illness, following through on recommendations of health care providers, and motivating changes that reduce health risks and prevent avoidable emergency room visits or hospitalizations. Medicaid MCOs and other organized delivery systems are also beginning to see the value in contracting for services that include medical respite or recuperative care¹⁷ and intensive case management services linked to housing assistance as strategies for managing the financial risk associated with avoidable hospitalizations and readmissions and meeting quality improvement performance requirements.

HENNEPIN HEALTH

In **Minnesota**, Hennepin Health, an organized delivery system functions as an Accountable Care Organization for county residents eligible for Medicaid. The Hennepin Health approach was designed to address underlying social, behavioral, and human services issues while treating patients' medical problems, using a coordinated patient and family-centered, comprehensive care plan to end the cycle of costly crisis care.¹⁸ Housing navigators play an important role in serving Hennepin Health members whose homelessness or residential instability has a significant impact on health-related vulnerabilities and service use. Working with social workers, community health workers, and health care teams in clinics or the county hospital, the housing navigators act as brokers, linking members to housing assistance programs that are coordinated by the county. The navigators focus on those members whose lack of housing is contributing to escalating medical costs, prioritizing those for whom housing is likely to have the greatest impact not only on quality of life but also on cost reductions, providing a return on investment that can help make the case for funding necessary supports. For just over 120 Hennepin Health members housed with this assistance, inpatient hospital admissions declined 16%, emergency department visits declined 35%, psychiatric emergency visits dropped 18% and outpatient visits increased 21% in the first year after placement in housing.¹⁹

6. What Purchasing Strategies Can States Pursue to Encourage Managed Care Contractors to Achieve Shared Goals for Beneficiaries Experiencing Homelessness?

State purchasing strategies with managed care contractors can provide opportunities and incentives to connect health services with housing resources that support stability and better outcomes for consumers with complex needs, while reducing avoidable costs. For example, State performance benchmarks for Medicaid MCOs related to quality measures or engaging high-risk members in care management services can provide additional incentives for plans to prioritize care improvements for members experiencing homelessness. When states contract with MCOs, for example, they may recognize and encourage services that help people with disabilities obtain and maintain housing as activities that improve health care quality, such as service coordination and case management.²⁰

MCO contracts may require plans to collaborate with interagency partnerships that link Medicaid services with housing assistance for beneficiaries with disabilities who are homeless, at risk of institutionalization, seeking to return to the community from an institutional setting, or for beneficiaries with multiple chronic health conditions needing care coordination and case management services. For example, Louisiana's contract with a behavioral health managed care plan includes responsibility for outreach to members who need PSH, specialized care management services, and management of a network of PSH service providers.²¹ Similarly, other State Medicaid MCO contracts may require plans or providers of health home services to have staff who understand how to assist these at risk beneficiaries to access housing assistance.²²

State Medicaid MCO performance measures need not be specifically targeted to improving care and maintaining housing for high-risk members to directly affect members experiencing homelessness. For example, in Medicaid contracts with MCOs or integrated delivery systems, some states, including Texas, Minnesota, and the District of Columbia, have adopted or are considering performance measures and financial incentives to reduce avoidable hospital readmissions and quality measures related to connecting people with outpatient care following hospital discharge. As plans examine their data in an effort to improve performance on state-identified measures, they often recognize that some of their high-risk members with frequent and avoidable hospitalizations, readmissions, and emergency room visits are experiencing homelessness. Generally, Medicaid plans have had limited success in locating and engaging these members in more appropriate care. In

response, some Medicaid plans are implementing innovative approaches to improve care, transitions, and services connected to supportive housing for homeless Medicaid members.

In **Texas**, the United Healthcare Medicaid plan pilot program that links health care utilization with HMIS data also contracts with local homeless coalitions to find and engage high-risk members, help them to develop a housing plan, complete a health risk assessment, connect with their primary care providers and with the health plan's care managers. When a homeless member is linked to housing assistance, the plan is making "barrier buster" funds available to help remove barriers to getting members into housing by paying for identification documents, security deposits, or other one-time costs. The plan expects these interventions to help reduce costs by ensuring members receive care in appropriate settings and help it achieve quality performance standards included in its contracts with the state Medicaid agency.

State contracts with Medicaid MCOs generally require plans to provide care management services, particularly for members with complex needs. States may hold MCOs accountable for developing individualized care plans for some types of beneficiaries and for reporting the number of members engaged in case management. However, state purchasers and Medicaid MCOs are increasingly recognizing the limits of telephonic care management services for members who have significant challenges related to chronic illness, co-occurring behavioral health disorders, and a history of homelessness or unstable housing. For these types of beneficiaries, states may encourage or require MCOs to offer face-to-face care management services provided by a worker who is trusted by the beneficiary and available to offer help with coordinating access to social services, such as food and housing, as well as medical care.

7. What Medicaid Policy or Coverage Changes Can States Pursue to Improve Health Outcomes and Reduce Costs for Beneficiaries Experiencing Homelessness?

A 2014 report released by the U.S. Department of Health and Human Services (HHS), and the accompanying Primer on Using Medicaid for People Experiencing Chronic Homelessness and Tenants in Supportive Housing, describes current and emerging practices in several states where Medicaid pays for some services in PSH for people experiencing chronic homelessness.²³ Medicaid benefits most often used to pay for services in PSH are optional

benefits that many states use to cover community behavioral health services, such as Assertive Community Treatment (ACT) or community support teams that deliver flexible, client-centered services in a range of settings. These Medicaid benefits are often limited by state policies to persons with serious mental illness.

For homeless beneficiaries with significant functional impairments, a few states are exploring the availability of certain community-based behavioral health services or allowing Medicaid plans to pay for support services that are comparable to client-centered services currently available through Medicaid benefits for persons with serious mental illness. States may allow MCOs flexibility to pay for services that are medically appropriate, cost effective substitutes for Medicaid state plan services included within the health plan contract, and plans can offer and cover such services as a means of ensuring that appropriate care is provided in a cost efficient manner. In addition, diversionary services may be effective in reducing the need for emergency or inpatient services for people with mental health and substance use disorders.

In **Massachusetts**, a Medicaid waiver enables the state to contract with managed care plans for behavioral health services including diversionary services as alternatives to inpatient services for persons with behavioral health disorders. The Community Support Program to End Chronic Homelessness (CSPECH) provides nonclinical support services for adults with behavioral health disorders who are experiencing chronic homelessness, helping them get and keep permanent housing and avoid hospitalizations. The program was initially established to serve beneficiaries with serious mental illness. As CSPECH demonstrated savings by reducing avoidable hospitalizations and helping participants achieve housing stability, it was expanded to include additional MCOs and a target population that includes chronically adults with a broader range of behavioral health disorders.

Among the most high-risk, high-cost Medicaid beneficiaries experiencing chronic homelessness, many have co-occurring health and behavioral health conditions. State purchasing

policies that reduce fragmentation in funding and delivery systems can facilitate promising models of care by multi-disciplinary teams to deliver integrated medical and behavioral health care and social supports in a range of settings, including home visits.

Conclusion

New strategies are required to respond effectively to homeless persons' needs for health-related support services including interventions that help people obtain and maintain stable housing. Medicaid agencies, plans, and providers are engaged in promising efforts to control costs while improving outcomes for beneficiaries experiencing homelessness. These efforts include cross-system and multi-agency partnerships working to end chronic homelessness as well as Medicaid payment and delivery system reforms. As purchasers of health care, state Medicaid agencies have critical roles to play in the delivery of more appropriate and cost-effective care for people with complex health and behavioral health care needs who experience homelessness.

Innovative purchasing incentive strategies and the enrollment of more homeless people into Medicaid managed care provide new opportunities for states to lead collaborative efforts to improve care for some of Medicaid's most vulnerable, high-cost and high-need beneficiaries. By educating Medicaid agency staff, managed care contractors and providers about housing services and supports, states can improve access to important housing resources for Medicaid beneficiaries with disabilities who are living on the streets or in emergency shelters, as well as for people with disabilities in nursing homes or other institutional settings. By better aligning Medicaid priorities and resources with homeless assistance programs, States can maximize opportunities to streamline access to supportive housing for the most vulnerable Medicaid beneficiaries and reduce avoidable health care costs while improving outcomes. Good planning, clear MCO performance standards, collaborative performance improvement initiatives and cross-system partnerships informed by evidence about what works, can better connect Medicaid beneficiaries with housing assistance, producing savings for taxpayers and MCOs and better outcomes for beneficiaries and communities.

Endnotes

- ¹ *The 2014 Annual Homeless Assessment Report (AHAR) to Congress – Part 1 Point-in-Time Estimates* (2014) U.S. Department of Housing and Urban Development (HUD)
- ² *The 2013 Annual Homeless Assessment Report (AHAR) to Congress – Part 2 Estimates of Homelessness in the United States* (2014) U.S. Department of Housing and Urban Development (HUD)
- ³ *ibid* (2013 AHAR – Part 2)
- ⁴ See The Commonwealth Fund (2014) *In Focus: Using Housing to Improve Health and Reduce the Cost of Caring for the Homeless* <http://www.commonwealthfund.org/publications/newsletters/quality-matters/2014/october-november/in-focus> and <http://aspe.hhs.gov/daltcp/reports/2011/ChrHombr.pdf>
- ⁵ See <http://www.medicaid.gov/Federal-Policy-Guidance/Federal-Policy-Guidance.html> and <http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-06-26-2015.pdf>
- ⁶ The Commonwealth Fund (2014) *In Focus: Using Housing to Improve Health and Reduce the Cost of Caring for the Homeless* <http://www.commonwealthfund.org/publications/newsletters/quality-matters/2014/october-november/in-focus>
- ⁷ SAMHSA has recognized permanent supportive housing as an evidence-based practice. For more information see: U.S. Department of Health and Human Services, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (2010). *Permanent Supportive Housing: The Evidence*. Rockville, MD: HHS Pub. No. SMA-10-4509.
- ⁸ Sadowski, L. S., Kee, R. A., VanderWeele, T. J., & Buchanan, D. (2009). Effect of a housing and case management program on emergency department visits and hospitalizations among chronically ill homeless adults: A randomized trial. *Journal of the American Medical Association*, 301(17), 1771-1778.
- Basu, A., Kee, R., Sadowski, L. S., & Buchanan, D. (2012). Comparative cost analysis of housing and case management program for chronically ill homeless adults compared to usual care. *Health Services Research*, 47, 523-543
- ⁹ Kaiser Commission on Medicaid and the Uninsured (2012) *Medicaid Coverage and Care for the Homeless Population: Key Lessons to Consider for the 2014 Medicaid Expansion* and Burt, M. R., Wilkins, C., & Locke, G. (2014). Medicaid and permanent supportive housing for chronically homeless individuals: Emerging practices from the field. *Washington, DC: Assistant Secretary for Planning and Evaluation, Department of Health and Human Services*.
- ¹⁰ See <https://www.dshs.wa.gov/sesalrdal/research-reports/dshs-integrated-client-database-0>
- ¹¹ See <https://www.dshs.wa.gov/sesalrdal/research-reports/identifying-homeless-and-unstably-housed-dshs-clients-multiple-service-systems>
- ¹² See http://www.csh.org/wp-content/uploads/2014/01/RH-CSH_MedicaidHMISMATCHSummary.pdf
- ¹³ See [http://pschousing.org/files/Connecticut%20Integrated%20Healthcare%20and%20Housing%20Neighborhoods%20Summary%20\(March%202012\).pdf](http://pschousing.org/files/Connecticut%20Integrated%20Healthcare%20and%20Housing%20Neighborhoods%20Summary%20(March%202012).pdf)
- ¹⁴ HUD Notice on Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing and Record-keeping Requirements for Documenting Chronic Homeless Status (July 2014) <http://portal.hud.gov/hudportal/documents/huddoc?id=14-12cpdn.pdf>
- ¹⁵ See <http://www.orgcode.com/product/vi-spdat/>
- ¹⁶ *Crisis Indicator: Triage Tool for Identifying Homeless Adults in Crisis. Economic Roundtable*. 2011 available at <http://economicrt.org/publication/crisis-indicator/>
- ¹⁷ For people who have been living on the streets or in emergency shelters, medical respite or recuperative care programs are designed to provide a safe place to stay, usually for a few weeks, when they are being discharged or diverted from a hospital. These programs often provide some nursing care or coordination with home health services and help to access appropriate follow-up care, as well as case management facilitate connections to housing and other ongoing services and supports. Medical respite and recuperative care programs often operate with support from hospitals, grant funding, and some Medicaid reimbursement for covered services.
- ¹⁸ See <http://www.startribune.com/in-a-year-bennepin-health-improves-care-for-poor-keeps-costs-down/207966191/>
- ¹⁹ See http://content.govdelivery.com/accounts/MNHENNE/bulletins/10c0a90#link_1435345157508
- ²⁰ CMS has proposed regulations for Medicaid managed care that will allow health plans to include costs for activities that improve health care quality as part of the medical costs in the numerator used to calculate the Medical Loss Ratio (MLR). For more information, see <https://www.federalregister.gov/articles/2015/06/01/2015-12965/medicaid-and-childrens-health-insurance-program-chip-programs-medicare-managed-care-chip-delivered>
- ²¹ See <http://dhh.louisiana.gov/assets/docs/contracts/305PUR-DHHRFP-SMO-2014-OBH.pdf> (PSH provisions of the RFP begin on page 54)
- ²² For example, see Health Homes for Patients with Complex Needs: California Concept Paper Version 2.0 available at [http://www.dhcs.ca.gov/provgovpart/Documents/HHP%20CP%202.0%20-%20DHCS%20Final%20Draft%20Version%20-%202015-04-10%20\(14\)Final.pdf](http://www.dhcs.ca.gov/provgovpart/Documents/HHP%20CP%202.0%20-%20DHCS%20Final%20Draft%20Version%20-%202015-04-10%20(14)Final.pdf)
- ²³ Wilkins, C., Burt, M. R., & Locke, G. (2014). A Primer on Using Medicaid for People Experiencing Chronic Homelessness and Tenants in Permanent Supportive Housing. *Washington, DC: Assistant Secretary for Planning and Evaluation, Department of Health and Human Services*. <http://aspe.hhs.gov/daltcp/reports/2014/PSHprimer.pdf>, accessed August 12, 2015
- Burt, M. R., Wilkins, C., & Locke, G. (2014). Medicaid and permanent supportive housing for chronically homeless individuals: Emerging practices from the field. *Washington, DC: Assistant Secretary for Planning and Evaluation, Department of Health and Human Services*. <http://aspe.hhs.gov/daltcp/reports/2014/EmergPrac.pdf>, accessed August 12, 2015.