

The Supportive Housing Network of New York

High-Cost Medicaid Users in Supportive Housing: Best Practices/Think Tank

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Conference Participants

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Introduction

In New York State, at the start of his first term, Governor Andrew Cuomo announced an ambitious plan to overhaul Medicaid and launched the Medicaid Redesign Team Initiative, a state-wide listening tour to gather information as to the best practices for reducing preventable costs in the healthcare system while improving care. The Network and its members attended those meetings, took state policymakers on tours of supportive housing and made a compelling case that, in order to reach the triple aim of healthcare reform, the state should invest in supportive housing. Supportive housing—affordable housing linked to wrap-around services—has been proven to reduce individuals’ use of the costliest systems of care including emergency rooms, inpatient care and psychiatric centers. The resulting Medicaid Redesign plan included a commitment to utilize a portion of the savings the State would be realizing as a result of capping Medicaid spending and investing those dollars in the Medicaid Redesign Team Supportive Housing Initiative, a program now three years old that has invested more than \$300 million into supportive housing for the very most vulnerable high-cost/high need users of Medicaid.

The Initiative required tenants of MRT-funded housing to be Health Home eligible and/or enrolled or meet the following criteria: have a Serious and Persistent Mental Illness, HIV/AIDS or cope with two or more chronic conditions. Health Home eligibility/assignments were made using a predictive algorithm but, because Medicaid information (and therefore assignments) were at least a year old, the Department of Health allowed providers to use the chronic condition criteria as a proxy for Health Home eligibility and, therefore eligibility to live in MRT-funded supportive housing.

The Supportive Housing Network of New York—using funding from the Langeloth Foundation—elected to convene a diverse group of individuals with great depth of experience in providing supportive housing to high-cost Medicaid users to enhance cross-learning in this quickly evolving field.

On December 5, 2014, therefore, experts from the supportive housing, health care, and health policy sectors convened to discuss successes and challenges from previous supportive housing interventions, best practices in program implementation and performance evaluation, and new initiatives on the horizon regarding supportive housing specifically for high-cost Medicaid users.

Takeaways from Presentations

Think-tank participants with intimate knowledge of supportive housing (SH) programs serving high-cost/high-need homeless people with chronic health conditions across North America were asked to give 15 minute presentations on their work including notable aspects of their implementation model and their programmatic relationship with high-cost Medicaid users. Afterwards, presenters and other invited attendees had a discussion inspired by the presentations and their varied research and practice experiences.

Stephen Hwang, MD, Center for Research on Inner City Health, St. Michael's Hospital, Toronto

PROJECT DESCRIPTION:

The At Home/Chez Soi Program was a demonstration project funded with a \$110 million grant from the Canadian federal government which sought to provide immediate housing with mental health supports for homeless individuals suffering from mental illness. The Mental Health Commission of Canada (MHCC) collaborated with groups of stakeholders in five cities (Vancouver, Winnipeg, Toronto, Montréal, and Moncton) to implement a pragmatic, randomized controlled field trial of 'Housing First', a low-threshold scattered-site housing intervention using rent supplements. The intervention group was split into two categories. The first, a high needs group characterized by psychotic illness and frequent use of either hospitals or jails, qualified for Assertive Community Treatment (ACT). The second, a moderate needs group, could be served by Intensive Case Management (ICM).

OUTCOMES:

- The intervention groups moved into stable housing more rapidly and remained housed at a higher rate than the control or Treatment As Usual (TAU) group. There were also improvements in quality of life and community functioning in the intervention group. There were no statistically significant improvements in mental or physical health status over 24 months.
- There was a significant drop in the number of days spent in institutions for the high needs segment of the intervention group.
- The TAU group experienced similar drops in emergency department use in the follow-up period as the groups receiving the Housing First intervention. Dr. Hwang explains the drop in utilization within the TAU group as a “regression-to-the-mean” effect, which is unsurprising in a sample of an extremely high needs population.

- Neither the intervention nor TAU groups as a whole demonstrated overall cost savings.
- Significant cost savings from the Housing First intervention were demonstrated in the top 10 percent of highest use participants; two thirds of these were in the group initially identified as “high needs” and one third were in the group identified as “moderate needs.” Savings were in large part due to a reduction in emergency shelter use.
- The demonstration program indicated that every dollar invested in housing and supports for the top 10% led to a savings of \$2.1 dollars in public costs.

Dr. Hwang believes the most important takeaways from his study are the effectiveness of differentiated service provision from a programming perspective and the importance of a control group in evaluations to accurately assess the impact of a particular intervention while accounting for natural regression to the mean.

Arturo Benedixen and Peter Toepfer, Chicago Center for Housing and Health

The Chicago Housing for Health Partnership (CHHP) was formed in 2003 to scientifically test the efficacy of supportive housing to improve the health of homeless individuals with chronic medical illnesses. The partnership includes hospitals, CHHP case managers, and providers of medical respite, temporary housing, and permanent supportive housing, all working in coordination with the CHHP lead agency, the AIDS Foundation of Chicago.

DESCRIPTION OF CHHP PROJECT:

CHHP engaged in a four-year randomized controlled trial of the impact of offering supportive housing to chronically ill individuals which took place between 2004 and 2008.

OUTCOME:

Studies published in JAMA and Health Services Research showed that intervention patients had significant reductions in hospital use and nursing homes with annual cost savings approaching statistical significance from \$6,300 to \$10,000, even after accounting for housing costs.

DESCRIPTION OF DECILE PROJECT:

In 2012-14, AFC's Center for Housing and Health sought to place 48 of the highest users of Medicaid who were homeless—individuals whose Medicaid costs ranked in the top six deciles—into

HUD-Homeless funded scattered site supportive housing. Potential participants were recruited based on reports of presumed high usage from social services providers and mobile teams targeting street homeless individuals, and were confirmed as top decile users by a Medicaid staff person. 72 high users of Medicaid were confirmed –representing only 20% of those individuals presumed to be high users from observational reports. All participants are living with at least two chronic illnesses and 75% of study participants are living with four.

OUTCOME:

In a non-randomized, non-controlled, pre-post evaluation analysis of 31 of these 48 patients who had been in supportive housing for at least 18 months, there was a 34% reduction in costs [after placement in SH]. Aggregate Medicaid costs went from \$1.2 to \$0.8 million, and there was an average annual cost savings of \$13,400 per person accounting for SH costs. For 9 of the 31 who were the highest users, there was a 51% reduction with a cost savings of \$31,000.

DESCRIPTION OF MCO PROJECT:

The Center is currently working on a demonstration program with Managed Care Organizations in Chicago based on the Decile Project outcomes that seeks to house 50 of MCOs' highest cost members who are homeless in supportive housing. The Center is asking the MCOs for a \$6,000-\$10,000 per person investment to help defray the cost of services for these individuals, with the expectation that MCOs will realize a significant return on this investment in decreased future health care costs.

CONCERNS:

Mr. Bendixen and Mr. Toepfer emphasized the need to recapture cost savings due to SH to reinvest money into more SH units. They discussed “alternate service dollars” as a mechanism through which an MCO could use Medicaid money to partially pay the cost of providing SH. Mostly, however, Mr. Bendixen and Mr. Toepfer raised the issue of the long-term dependability of Medicaid/MCO funding for supportive housing: “what happens after two or three years when somebody stabilizes and are no longer high users of Medicaid dollars or health care dollars? We’re not ready to say to the MCOs, ‘Give us money to create new units, and we’ll house your high users’ because we don’t know whether they’ll continue to give us that money after a year or two.”

Joshua Bamberger, MD, University of California San Francisco and Mercy Housing

DESCRIPTION OF DIRECT ACCESS TO HOUSING:

Dr. Bamberger helped create the Direct Access to Housing Program in 1999 supported through new city revenue during a period of strong economic growth in San Francisco.

The program was designed to house high-cost/high need chronically homeless individuals, but the units were initially distributed to homeless service providers with little guidance as to how to identify high cost/high need individuals, so Dr. Bamberger estimates that only half the 1,700 units created are filled with individuals who have complex medical problems.

OUTCOMES:

Dr. Bamberger said he deeply regretted not targeting his Direct Access to Housing units to the most medically challenged chronically homeless: “I had 1,700 units of housing in San Francisco. If I’d targeted, I believe I could have come close to ending homelessness for chronically homeless people with advanced medical illness.” Dr. Bamberger has completed some initial analyses that indicate that higher quality architecture housing has a significant impact in reducing mortality for vulnerable homeless adults and people exiting nursing homes.

DESCRIPTION OF SOCIAL IMPACT FUND PROJECT:

As part of a five-site initiative with the Corporation for Supportive Housing through the Social Innovation Fund of Corporation of National and Community Service, the San Francisco Department of Public Health, the San Francisco Health Plan and Tenderloin Neighborhood Development Corporation are engaged in a demonstration program that looks at the health care utilization of 50 high cost/high need homeless individuals into apartments at a single-site supportive housing residence, Kelly Cullen Community compared to a randomly assigned comparison group. The subjects were selected from among 30,000 members of the public Medicaid managed care program serving seniors and persons of disability. Inclusion criteria included high utilization of health care services and homelessness at the time of the randomization. Data analysis on housing stability, health outcomes, and public costs is being performed by local researchers led by Dr. Bamberger and supported by a team of researchers at New York University and is ongoing. The project is utilizing healthcare utilization information cross referenced with homelessness data to determine eligibility.

OUTCOMES:

Analysis of the first year post intervention are very promising in showing a significant return on investment for the healthcare system that invests in supportive housing as a healthcare treatment. Dr. Bamberger reported that he found that in the year after the intervention the control group’s health care costs increased (which is the first study of supportive housing in which the comparison group’s health care utilization does not decrease after enrollment in a study), while the treatment group’s health care costs decreased an average of \$29,000 per person. One hypothesis for the fact that the comparison group increased in healthcare costs during the first year of the study is that the extremely limited availability of affordable

housing in San Francisco made it unlikely that the comparison group would have been able to access housing during this time except through this new housing opportunity.

CONCERNS: While Dr. Bamberger harbored concern about usage and/or cost being the only criteria for health-housing intervention, he argued for the development of different solutions – paid for by non-healthcare funding streams -- for people who don't qualify for housing under cost reduction/healthcare intervention rationales, but stated unequivocally that if supportive housing was being used as a healthcare intervention and the goal is reduction in healthcare costs and measurable improved healthcare outcomes tenants should be the most medically challenged (defined broadly to include behavioral health and chronic medical conditions). Dr. Bamberger believes clinical markers could be used to identify individuals who would have a cost and healthcare outcome benefit from supportive housing in addition to identifying individuals due to prior high utilization of healthcare services.

Joe Finn, Massachusetts Housing and Shelter Alliance

DESCRIPTION OF HOME & HEALTHY FOR GOOD (HHG):

The Massachusetts Housing and Shelter Alliance (MHSA) is a public policy advocacy organization representing 100 community-based service providers across Massachusetts. MHSA created Home & Healthy for Good (HHG) as a pilot project in 2006, funded by a line item in the Massachusetts State Budget. The state funding for HHG is flexible, allowing providers to use HHG funding for supportive services, housing, or both. HHG is a leveraged model; providers use HHG funding to leverage additional public or private resources in order to provide permanent supportive housing for chronically homeless individuals.

OUTCOME:

The most recent pre-post evaluation with no control group puts total public savings per person at \$9,118 after paying for the intervention. Medicaid costs were reduced 67% from \$26,124 to \$8,500.

DESCRIPTION OF HUES TO HOME:

Working with hospitals, shelter providers and outreach teams, MHSA created a second initiative targeting the highest users of emergency services, High Utilizers of Emergency Services (HUES) to Home. Participants were identified through a mix of hospital data, Medicaid data and cross-system case conferencing.

OUTCOME:

Analysis of the outcomes for HUES to Home is ongoing.

DESCRIPTION OF COMMUNITY SUPPORT PROGRAM FOR PEOPLE EXPERIENCING CHRONIC HOMELESSNESS (CSPECH):

CSPECH, or the Community Support Program for People Experiencing Chronic Homelessness, is an initiative utilizing Medicaid funding under the Massachusetts 1115 Waiver to provide service dollars to organizations placing chronically homeless individuals into permanent supportive housing. (Important note: Massachusetts inaugurated universal healthcare in 2006.) CSPECH was initially a collaboration with one Managed Care Entity (MCE), through the Massachusetts Behavioral Health Partnership (MBHP). CSPECH reimburses providers for the wrap-around services in supportive housing. Providers partner with a Medicaid billing umbrella organization, which then bills the MCE for reimbursement (configured as a monthly payment).

OUTCOME:

CSPECH has been recognized nationally as a model for supporting permanent supportive housing with Medicaid dollars. In 2011, MHSA's advocacy resulted in MassHealth lifting the cap on CSPECH, allowing this cost-saving model to reach more individuals served by MBHP. By 2012, MBHP estimated that CPSECH had already created a net Medicaid savings of over \$3 million. However, at this time the CSPECH benefit was available only to individuals receiving behavioral health services through MBHP. MHSA is currently using the Pay for Success initiative (described below) as an opportunity to expand CSPECH to additional MCEs, thereby significantly increasing the population eligible for CSPECH.

DESCRIPTION OF PAY FOR SUCCESS:

MHSA and Governor Patrick were three days away from announcing its Pay for Success (PFS) program, a Social Impact Bond by which investors pay for permanent supportive housing to be repaid by the Commonwealth of Massachusetts once performance goals are met. A key innovation from MHSA's perspective is that the PFS will require that additional MCEs in Massachusetts offer the CSPECH benefit.

Elizabeth Misa, New York State (NYS) Department of Health Medicaid Redesign Team (MRT)

DESCRIPTION OF MRT PROJECT:

The NYS MRT project aims to provide SH to New York's high-cost Medicaid users. The New York initiative began in 2011, and \$388 million have been invested to date. The New York program receives referrals from shelters, the NYS Department of Homeless Services, the NYS Human Resources Association, the NYS Office for Persons with Developmental

Disabilities, and self-referrals from homeless individuals. Eligibility for nearly all units is linked to Health Home eligibility. To be eligible for Health Home services, participants must have either a serious and persistent mental illness, HIV/AIDS, or at least two other chronic conditions, though there are no requirements around prior health care utilization or costs.

In New York, almost all SH programs are linked to Health Homes to ensure consistent health care management.

The program collects Medicaid identification numbers and other basic information for every individual receiving supportive housing in order to facilitate a future evaluation to examine changes in health care utilization and health care costs. NYS is currently working on a plan for an evaluation to include a matched comparison group.

OUTCOME:

DOH is currently working on an evaluation of MRT and is beginning to collect data from supportive housing providers using Medicaid numbers as identifiers.

THEMES

The discussion could broadly be grouped into a set of concerns around implementation, targeting, evaluation and funding, representative of the spectrum of providers and researchers present at the convening. There is overlap between these arenas, reflective of the organic back-and-forth of the think tank.

IMPLEMENTATION

Medicalization

- Medicaid is often restrictive as to what services are reimbursable, which can clash with the ‘whatever it takes’ nature of services in supportive housing.
- There was a concern that requiring supportive housing recipients be covered by Medicaid will change the focus of the SH model from ending homelessness to decreasing health care utilization.
- Most nonprofits who work in supportive housing do not have the capacity to bill Medicaid, and will require significant infrastructure investments to do so
- There was concern that using Medicaid money to pay for services could negatively impact the SH model: if SH feels like a medical intervention, people may not want to live there. Participants familiar with the birth of supportive housing noted that quite a lot of licensed housing was available when there was widespread homelessness: the people who were

living on NYC streets preferred homelessness to a setting that required service participation.

TARGETING

Towards a Targeting Best Practice

- The entire day of presentations and discussions emphasized the importance of targeting the highest-cost Medicaid users for Medicaid-funded SH in order to realize significant cost savings in the Medicaid system.
- A repeated frustration amongst attendees was the lack of availability of data for effective targeting of such individuals. The question was raised as to how can housing providers, care coordinators, social workers, and others at the housing gateway target high users without systematic and direct access to protected Medicaid usage data.
- Suggestions were made for using healthcare diagnosis information as a reliable proxy for direct billing information
- Types of targeting models used previously have included looking at historical health care use data (e.g., previous year Medicaid costs) and developing “predictive models” to identify people likely to have high costs or high needs in the future. There has not yet been good research revealing “best practices” in targeting.
- It is important to note that some chronically homeless individuals are neither on Medicaid nor high users, yet may still have high needs. In fact, some chronically homeless individuals are actually care avoidant. Targeting measures must be clear about who exactly the program seeks to serve and recognize that targeting based on costs alone may miss a vulnerable segment of the chronic homeless population.
- Some participants found denying available housing assistance to clients simply because individuals did not meet the threshold for high Medicaid usage morally troubling. However, there was consensus that supportive housing funded by health departments should target those for whom housing is a medical necessity, and, if Medicaid is funding housing, should target Medicaid high users. Other systems need to be optimized to care for people who are homeless but are not necessarily high-cost Medicaid users.
- There was discussion about developing less service-intensive interventions for people requiring less ongoing support
- So far, NYS has targeted SH to people who on the aggregate tend to be high-cost. For example, New York has focused on individuals who are homeless and mentally ill and/or have problems with substance abuse. However, there are large

variations in usage and costs within these broad groupings, as demonstrated in the morning presentations; in other words, not all people who are homeless and have mental illness or substance use are high cost. Additional targeting is therefore critical for Medicaid-funded SH to realize significant cost savings in the Medicaid system.

- NYS has developed a tool to track Medicaid data for all those placed in Medicaid-funded SH so as to accurately represent costs saved. The tool is being used to inform evaluation.

PERFORMANCE AND OUTCOME EVALUATION

Study Design

- The quality of performance data and the nature of its collection can improve program design, prioritize the most effective interventions, and garner support to sustain and scale successful SH.
- Researchers emphasized the importance of control groups or comparable alternative research strategies to ensure that the results of evaluations are accurate representations of programmatic interventions and account for ‘regression to the mean,’ a natural reduction in use over time that is observed for people with abnormally high baseline variables that may make it hard to distinguish the actual effects of an intervention in the absence of a comparison group. Having control or comparison groups in an evaluation is important to more accurately parse out the effects of an intervention.
 - Some present at the meeting felt that it was unethical to continue to do randomized controlled trials since previous SH studies have demonstrated significant differential outcomes.
 - In the absence of forming a physical control group, propensity score matching was suggested as a way to form comparison groups.
- Researchers discussed the need to use validated questionnaires and assessment instruments, and corroborate evidence from multiple sources, when possible.
- There were questions raised about how providers should consider regional variation in the demonstration of program successes such that stakeholders are assured that a successful intervention in Massachusetts is reflective of the potential for program success in Illinois?

Re-imagining Value

- Attendees urged the need to think beyond cost savings as the only measure of a positive return on investment. There must be consideration of other outcome measures, especially

those that consider cost along with improved health outcomes. Many interventions that are good for health are not necessarily cost-saving, and we accept this as a society.

- It is also important to recognize that there are some high-cost individuals who, even after acquiring SH, will demonstrate only limited or no cost savings at all but will have improved health and well-being indicators.
- One potentially important metric is the QALY which is an acronym for quality adjusted life year. QALYs consider both the quality and the quantity of life lived, and are used as a way to determine whether health interventions are good values for money. Generally interventions are considered good values when they cost \$100,000 or less per QALY gained, and many health interventions (i.e., medications, procedures) commonly paid for by health insurances actually cost much more than this.

FUNDING

Savings Recapture

- Those convened stressed the need to recapture savings from SH interventions for the maintenance and growth of SH for high cost Medicaid users.
- There is an added challenge to savings recapture when the appropriate target of such savings does not traditionally bill Medicaid. In other words, how can providers ensure savings from SH are reinvested in housing-specific interventions in addition to other preventative health interventions?
- Hennepin County, Minnesota interventions were cited as potentially instructive examples of savings recapture.
 - Federal approval for numerous services as long as they fall under the capitated rate for an individual underlies the success at savings recapture in these models. When overall costs are under the capitated rate, savings can be recaptured for the continued provision of social support services, including housing.
- In NYS, the Medicaid global spending cap funds SH and efforts to track savings will support reinvestment in SH.
- Related to savings recapture is the challenge of upfront funding for SH by managed care organizations (MCOs) and related entities. And, since patients can migrate across MCOs, it may be important both for care coordination and savings recapture that compatible agreements are reached with all MCOs in a region.
- Federal matching for regional SH interventions was thought

to be important for its financial future. This model is actively being pursued in NYS.

Medicaid funding for services and housing & MCOs

- Think Tank participants raised the challenge in considering Medicaid and MCO funding for supportive housing services in deciding what happens when a high-cost user is no longer a high-cost user.
 - A repeated concern amongst providers was how to incentivize payers to continue seeing the cost-effectiveness of SH after a formerly high-cost user has stabilized.
 - On a common sense level, halting SH after cost savings have been achieved risks losing many if not all of the gains of the intervention. The question, then, is how to convincingly demonstrate this to payers to protect the investment.
 - The support in supportive housing is both voluntary and ongoing – staff prevent small issues from becoming big ones and tenants from losing their housing. Even when people aren't costing as much, they may still need support due to underlying issues such as mental illness. Therefore, concerns were raised around payers attempting to determine that people are “no longer eligible” for services. This concern highlighted the importance of long-term data collection and for careful review of how many services in supportive housing might be safely off-loaded to Medicaid and/or Medicaid Managed Care without risking clients' tenancy.
- Currently, state-funded service contracts give private investors the confidence to invest in single-site supportive housing. Supportive housing providers were concerned that this source of development funding may no longer be available if Medicaid is used to pay for services in supportive housing.
- There is a need to educate healthcare providers about housing and teach SH providers about healthcare and determining who does what when.

LOOKING AHEAD: CONCLUSIONS & NEXT STEPS

Attendees collectively reaffirmed the importance of the continued engagement between social service and healthcare providers. SH is a major part of the discourse on the role of the social determinants of health in ensuring better health outcomes for vulnerable—and high-cost—individuals.

Key Points

- Multiple experts reaffirmed that SH is critically important for the health of the most vulnerable homeless individuals.
- While funding for services in supportive housing via Medicaid and Managed Care Organizations has potential benefits, discussions about Medicaid/Medicaid Managed Care funding replacing general fund service dollars need to address supportive housing providers' concerns about model impact:
 1. Medicaid/Medicaid Managed Care services may not be offered continuously, jeopardizing the effectiveness of the model.
 2. Multiplicity of MCOs in a locality—and MCO turnover—may impact service continuity.
 3. Medicaid funding may currently be overly restrictive both in terms of services offered and individuals served.
 4. Medicaid funding requires significant infrastructure changes for nonprofit providers who are not currently able to bill Medicaid.
 5. Reliance on Medicaid-funding for services could impact the desirability of supportive housing for the most in need, who are frequently service-resistant.
- Accurately targeting Medicaid-funded SH to the highest-cost Medicaid users is essential to realizing significant cost savings to the Medicaid system.
- SH stakeholders must include cost-effectively improved health and wellbeing in the conversation on the value of SH. Cost savings alone are too narrow a metric for success.
- Recapturing SH savings for reinvestment and federal matching of SH funding are important for the sustainability of SH.
- Using rigorous evaluation designs, including comparison groups, for SH evaluations will help prioritize the most effective interventions. Whereas randomized controlled trials may be unethical, alternative strategies, such as forming comparison groups via propensity score matching, can help in obtaining quality research.
- Alternative health and housing models must be developed for homeless individuals with complex health issues but whose behavioral health needs do not require the types of ongoing support typically offered in supportive housing.

Innovations in the field

- In Houston, housing and health systems share data so that SH providers receive names of high users stripped of any other identifying information. These efforts are a result of collaboration between CSH and partners, including UnitedHealthCare.

Peggy Bailey

- Hennepin Health is an instructive model through its Accountable Care Organization structure and use of social service navigators who match clients to available SH options. Dr. Bamberger also spoke briefly of other regional models for New York: Salt Lake City because of its success at targeting, San Francisco because of its offering of differentiated services, and Los Angeles because of the use of a flexible housing subsidy pool to fund housing.

Dr. Bamberger

- There was the suggestion of a PACE-like program for homeless individuals. PACE (Program of All-inclusive Care for the Elderly) is a Medicare and Medicaid program that helps meet health care needs in the community instead of within care facilities. Under PACE, a wrap-around bundled fee goes to agencies that provide outpatient primary care, mental health services, and case management.

Dr. Hwang