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Housing and Medicaid

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Highlights

- The cost of health care is significantly impacted by non-clinical issues, including access to affordable, safe housing.
- Ohio has significant rates of housing insecurity and is one of the nation's poorest performers in terms of housing equity.
- Medicaid can and has played a role in connecting the chronically homeless and housing insecure to services that improve the economic wellbeing and health of Medicaid enrollees.
- Ohio should support policies which increase access to subsidized housing and hold accountable providers and managed care plans responsible for achieving value in Medicaid.

Introduction

In Ohio, Medicaid represents one of the most complex and significant policy investments of the state. The resources committed, which equal nearly 25 billion each fiscal year, have been the subject of intense scrutiny by state and federal policymakers. The question of how the resources are allocated and the underpinnings of those choices are often made ideological, escaping the necessary examinations of efficiency and value creation. This Issue Brief attempts to unpack some of this dynamic by looking at the intersection of Medicaid and housing, how some states are addressing the issue of housing insecurity through Medicaid, and what the policy opportunities for innovation may be.

Why Housing

In a study of the 34 industrialized nations that comprise the Organisation for Economic Co-operation and Development (OECD), the United States is one of the most inefficient in terms of achieving value in its health care spending.[1] The U.S. has the highest overall spending in terms of Gross Domestic Product. And, while the average OECD nation spends about $2 on social services for every $1 in health care spending, the United States invests about 55 cents. When incorporated into overall spending, this places the U.S. in a much better position, placing it 13th overall in terms of spending outlays. But, with the U.S. ranking 27th in terms of life expectancy, value is not being achieved.

Ohio is one of the worst states when it comes to achieving value. The Health Policy Institute of Ohio's recently published Health Value Dashboard underscores this point, ranking Ohio 46th out of the U.S.' 50 states and the District of Columbia.[2] In this study, authors cite the factors impacting overall health, noting that 80 percent of the influence comes from non-clinical factors, including the social and economic environment, of which access to affordable, safe housing is cited. In regards to these housing-based measures, where Ohio ranks in the middle of the pack overall, it does very poorly in regards to equity, showing that individuals with less education,

disability, who are African-American, and/or are lower income, are at much higher risk in terms of overall health outcomes.

Housing and Health

Evidence suggests Ohio has a housing insecurity problem. Insecurity can be defined as being severely cost-burdened, which means a household is spending nearly 50 percent of its income on housing. Nationally, 19 million Americans pay over half their income on housing. In Ohio, this translates to nearly 228,149 owners (about 1 in 10 Ohioans who own a home) and 387,565 renters (about 1 in 4 Ohioans who rent).[3] With the volume of individuals and families who are housing insecure, Ohio places itself at great financial risk due to the downstream costs associated with housing insecurity.

A myriad of research has been conducted to show the connection between housing insecurity, health outcomes, and cost. In fact, in regards to outcomes, being homeless means one's life expectancy is 30 years lower than the general population.[4] A study conducted in the state of Washington reinforces this statistic by documenting that housing insecure individuals were about twice as likely to report poor health or delay doctor's visits because of costs, even after adjusting for demographic or socioeconomic factors.[5] In the case of very young children, a multiyear study, conducted between 1998 and 2007, reinforced much of the same, showing that housing insecurity has significant negative health associations for children, including poor mental health, risk of injury, elevated blood pressure, respiratory issues, exposure to infectious disease, and lack of access to medical services.[6] Testimony given by Children's Healthwatch at Ohio's Commission on Infant Mortality highlighted a number of pieces of research citing the negative effects housing instability has on the food insecurity of kids, mother's depression, malnourishment, subsequent mental disorders, low vaccination rates, and lower educational achievement.[7] These outcomes not only affected children as children, and the issue of infant mortality, but were also associated with long-term problems, including developmental delays, risk of increased hospitalization, behavioral health problems, and increased risks as adults in terms of chronic disease. This research, in aggregate, indicates that the dangers of housing insecurity, financially and in terms of health outcomes, are considerable. Importantly, then, housing stability as a policy endeavor needs to be understood in terms of how it affects individuals' outcomes in terms of health and health expenditures.

Programs which have provided housing subsidies have shown to improve health outcomes for children.[8] Beyond health outcomes, looking at financial data compiled by the Center for Outcomes Research and Education (CORE) and Enterprise Community Partners (Enterprise), the beneficial intersection of housing security and Medicaid costs is apparent. This CORE/Enterprise work, which looked at multiple housing types and settings, found that secure housing led to overall Medicaid costs being reduced by 12 percent, primary care visits going up 20 percent, emergency department visits going down 18 percent, residents' access to services being improved, and overall monthly member costs for Medicaid recipients being driven down.[9]

Integrating Housing and Medicaid

Ohio's Medicaid expansion did a lot to alleviate the economic burden of medical expenses on housing. In the state's statutorily-required assessment of Ohio's Medicaid expansion, 48.1 percent of survey respondents indicated it was easier to remain current on their rent or mortgage.[10] Beyond the expansion of coverage, other states have leveraged Medicaid to address the issue of housing insecurity as an element of cost containment and economic advancement, generally.

In California, the state pursued a waiver called the Whole Person Care Program (WPC) which sought to develop policies that coordinated care for populations between multiple settings and social service environments.[11] This program, which focused on reducing inappropriate emergency department and inpatient utilization, cited access to housing as one of its key coordinated services. It did this by developing pilots which mandatorily involved one managed care plan, a public agency (potentially including a housing authority), and two other key community partners that would assist in addressing the unique needs of any given population. In regards to housing pilots, interventions could include tenancy-based care management supports (where individuals are in need of medically necessary housing) and county housing pools (which increase access to subsidized housing through a local government). Key to these interventions is a "housing navigator" who would be obliged to meet the coordination guidelines established for managed care plans. This navigator would then serve as a key resource in connecting consumers to bridge housing, permanent supportive housing, recuperative care, or other supports. In WPC, 11 housing service pilots and 17 flexible housing pools were created. While this program is relatively new, metrics associated with these efforts include the percent of homeless persons who are permanently housed for greater than six months, the percent receiving services based on an managed care plan referral, and the percent of those who were referred supportive housing and were able to achieve it.

Recently, through the Centers for Medicare and Medicaid Services (CMS) Innovation Accelerator Program, a number of states worked with the federal government to integrate the coordination functions of the federal agencies of Housing and Urban Development (HUD), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Office of the Assistant Secretary for Planning and Evaluation (APSE), and the U.S. Interagency Council on Homelessness.[12] In Louisiana, the state worked to leverage Medicaid for permanent supportive housing (PSH) through a strictly "Housing First approach," meaning there are no contingencies for client participation such as sobriety. This program, developed after hurricanes Katrina and Rita, leverages state Medicaid data to identify individuals with PSH needs and then matches them with a Low-Income Housing Tax Credit Program and contracted agency. Specifically, the state leverages its current state plan authorities with its 1915(c) and 1915(i) waivers. With its 1915(c) waivers, the state reimburses for pre-tenancy and/or tenancy crisis services as well as tenancy maintenance. With its 1915(i) waiver, the state reimburses for mental health services within its supportive housing, though face-to-face interactions are mandatory. As a condition of participation, all providers must work with all individuals with disabilities. Louisiana also

included rent subsidization in this waiver, but only for a limited period associated with the hurricanes.

In Massachusetts, managed care plans have an incentive built in their contract to work with the chronically homeless.[13] This program also relies on an 1115 waiver designed to address coordinated services through managed care. Since the inception of the program, Massachusetts has seen an average annual Medicaid savings of $15,468 per person. Moreover, utilization patterns changed with 9 in 10 enrollees decreasing their use of the emergency department to address basic health needs.

Beyond these specific states, the policy examination on approaches to integrating Medicaid and housing is robust. A recent National Academy for State Health Policy publication identifies the ways in which states have leveraged their state plan and waiver authorities to increase access to supportive housing services.[14] Importantly, when looking across states and their authorities, Medicaid funds are not allowed to be used for non-institutional room-and-board costs, though they can be used for the case management activities of housing and health providers alike. This is a key foundational factor in understanding the role of Medicaid in housing. Simply put, Medicaid cannot subsidize occupancy – it can only provide funding for case management services for individuals who are at risk.

The Role of Managed Care

The role of managed care will be key in understanding the connections for addressing housing insecurity in Ohio's Medicaid program. In several states, managed care has been contracted to address the needs of the homeless and the housing insecure. Within managed care, in states like Massachusetts, Louisiana, and Illinois, metrics associated with addressing the issue of homelessness and insecurity are built into the quality measurements collected by the state for the purposes of reimbursement. This is extended to dual eligible populations which, if looking at Ohio, can be represented by the coordination connection between the plans and the Area Agencies on Aging. Interestingly, in Pennsylvania, the behavioral benefit allows for an innovative collaborative relationship between counties, managed care plans, and the state. Since 2008, collaboratives that include counties and plans have been able to leverage savings from their community-based services to finance activities of the Pennsylvania Housing Finance Agency.[15] These activities have been used to build housing and support operating and rental resources, as well as move-in expenses.

Beyond the role of case management, it will be interesting to see how Ohio and other states will approach the utilization of the "in lieu of" regulation dealing with managed care. For background, "in lieu of services" refers to an authority of states to implement alternative services in settings that are not included in a state plan but are deemed medically appropriate, cost-effective substitutes within a contract with a managed care plan.[16] This authority, which was clarified in the federal government's review of the managed care regulations, does not

seem to allow federal funding for services completely unrelated to the state plan, but it may be an area of policy exploration as states seek to tackle the social determinants of health.

Conclusion and Recommendations

The intersection of housing and health care is well-documented and suggests that increasing housing security leads to better health outcomes, greater economic stability for individuals, and lower costs to state Medicaid programs. Many states have realized this connection, leveraging multiple authorities through the state plan or waiver processes to address the needs of the housing insecure and chronically homeless. Despite this innovation, however, reimbursement from Medicaid is limited to state plan services delivered, with some augmentation provided through case management, particularly through that of managed care plans. The "in lieu of services" provision may provide some opportunity for states to provide reimbursement for different services provided, though it may be difficult to achieve approval from the Centers for Medicare and Medicaid Services on regulatory and legal grounds.

Beyond direct reimbursement for housing, a number of tools are available to states to increase the potential for addressing housing insecurity. This includes, but is not limited to, adjusting contracts with managed care plans and providers by focusing on those measurements which address housing needs. Beyond that, states need to continue to invest in subsidized housing programs to hold down costs in Medicaid. Ohio recently considered an increase in the fees collected by the Ohio Housing Trust Fund – a program which was previously slated for elimination. Policymakers concerned with escalating costs in Medicaid should increase the housing opportunities for the hundreds of thousands of Ohioans who are housing insecure and homeless. What's more, the Ohio Department of Medicaid, utilizing its authorities through its contracts with managed care, the state plan, and its waiver process, should consider formally addressing the disconnect between these two systems as a way to continue its work in value-based reimbursement.

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