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Medicaid Policy Options for Services to Benefit Chronically Homeless Individuals: A Report from Massachusetts

Substance Abuse and Mental Health Services Administration Grant: 1H79SM062436

Massachusetts Department of Public Health Bureau of Substance Addiction Services - MISSION: Housed

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Executive Summary

Background

At any given time there are over half a million people experiencing homelessness in the U.S., 15% of whom would meet the federal definition of chronic homelessness.[1] Although considerable efforts have reduced chronic homelessness in Massachusetts, at last reported count, the Massachusetts chronically homeless individual population stands at 1,272 individuals.[2] Chronically homeless individuals have higher morbidity and mortality rates than the general population and their Medicaid costs are high due to frequent utilization of emergency departments and multiple hospitalizations. Even with widespread bi-partisan commitment to the population, there is room to close gaps in services.

In recent years the Centers for Medicare and Medicaid Services (CMS) shared options and flexibilities within Medicaid to improve services for the chronically homeless members. Massachusetts has long had a service model for this population, available to MassHealth (Massachusetts' Medicaid program) members who are enrolled in MassHealth's managed behavioral health care contract with the Massachusetts Behavioral Health Partnership (MBHP): Community Support Program for People Experiencing Chronic Homelessness (CSPECH).

Methods/Analysis

The Cooperative Agreement to Benefit Homeless Individuals (CABHI-State) grant to the Massachusetts Department of Public Health from the Substance Abuse and Mental Health Services Administration involved MassHealth from its outset. As part of the CABHI project, a Medicaid Specialist was secured who reviewed the policy options outlined by CMS. Of the options analyzed, one was most aligned with this project: amending managed care contracts to include Medicaid reimbursable support services for chronically homeless individuals. Leveraging various sources of data (including the Annual Homeless Assessment Report and service provider figures), possible costs and utilization for MassHealth contracts were projected. Informed by these calculations, MassHealth required the Managed Care Organization / CarePlus and Senior Care Options contracts to leverage CSP for chronically homeless individuals, similar to how used by the MBHP CSPECH model. As of this writing, Massachusetts is in the process of requiring this leverage of CSP for chronically homeless individuals within the Massachusetts' Medicaid-Medicare demonstration program (One Care). Recent data has confirmed estimation that reductions in healthcare utilization offsets service provision costs leading to a healthy return on investment.[3]

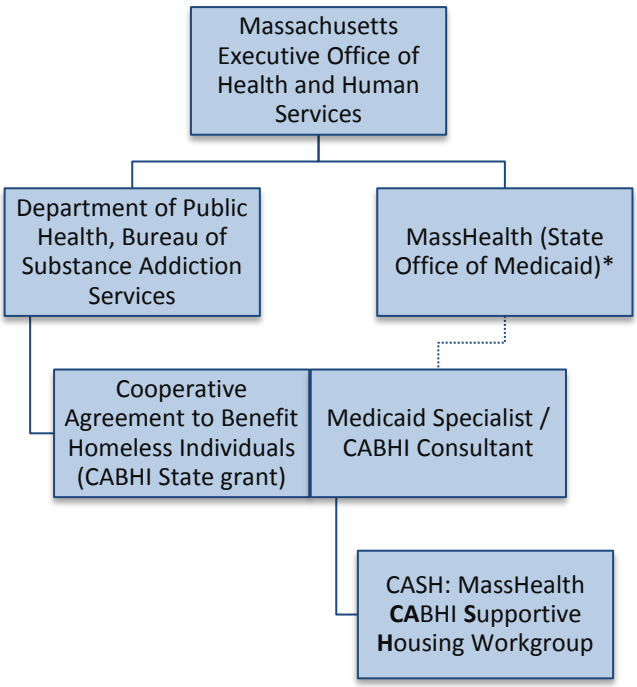
Lessons Learned/Recommendations

This grant funded administrative and implementation work to add Community Support Program services for chronically homeless individuals to two Medicaid managed care contracts by completing the steps outlined in this report:

1. Identify staff resources: Medicaid Specialist (with CABHI funds)
2. Target the population: Chronically homeless individuals
3. Select a service model: CSPECH
4. Confirm the appropriate authority: Medicaid managed care contracts

5. Estimate utilization, costs and offsets: Estimated costs would be offset by savings achieved by reductions in other health care spending.

The primary recommendation is for state Medicaid agencies and managed care plans to explore similar options to add services through the appropriate authority. To perform this work, agencies and health plans should dedicate staff resources to specialize in social determinants of health. To best coordinate efforts, all stakeholders should continually consider how to use Medicaid funds for medically necessary and permissible Medicaid support services paired with separately funded housing resources.



*MassHealth members may be in Fee-for-Service or managed care contracts such as Managed Care Organization / CarePlus, Senior Care Options, One Care as well as the state's Primary Care Clinician (PCC) plan. Members may have various coverage types depending on their eligibility (Standard, CommonHealth, CarePlus or Family Assistance)

Background

CABHI and Medicaid Specialist Position:

This report is made possible through the Substance Abuse and Mental Health Services Administration (SAMHSA) Enhancement to MISSION: Housed Cooperative Agreement to Benefit Homeless Individuals (CABHI-State) grant to the Massachusetts Department of Public Health's (DPH) Bureau of Substance Addiction Services. The Massachusetts CABHI grant aimed to implement the MISSION model and a Housing First approach to provide permanent supportive housing to **chronically homeless** adults (see box) in the Boston area spanning 2013 – 2016. The MISSION (**M**aintaining **I**ndependence and **S**obriety through **S**ystems **I**ntegration, **O**utreach and **N**etworking) model is a time-limited, yet flexible, integrated behavioral health intervention which is listed as a SAMHSA's National Registry of Evidence Based Practices. The CABHI Enhancement component funded a full-time Project Specialist situated within Massachusetts' Office of Medicaid (MassHealth) to explore the opportunities under federal and state authorities to expand access to supportive housing services for Medicaid members. Within MassHealth, this position functions as a Project Manager. Due to the grant objectives, this report focuses on challenges of and recommendations for chronically homeless individuals, many of whom have co-occurring substance use and mental health disorders.

> According to the US Department of Housing and Urban Development (HUD), a **chronically homeless** individual is a person with a disability residing in a place not meant for human habitation, a safe haven, in an emergency shelter, or in an institutional care facility (for fewer than 90 days and had been living in said places beforehand.) Homelessness, as defined above, must be continuous for at least 12 months, or on at least 4 separate occasions (separated by a week) in the last 3 years, where the combined occasions total a length of time of at least 12 months.
>
> See Appendices for more definitions.

Problem

The need for such a project is evident by several factors: the persistence and high costs of chronic homelessness, the connection between health and housing, and gaps in available services.

Population Size

- According to the US. Department of Housing and Urban Develop (HUD), more than half a million people in the U.S. experience homelessness at a given time, of whom over 75,000 were **chronically homeless individuals**. In Massachusetts, while the chronic homeless individual population is decreasing, it still stands at 1,272.[2, 4]
- For the past few decades, the homeless population mean age has increased to age 50,[5] well above the national general population mean age of 37.[6]
- Since 2014, many more chronically homeless individuals have become eligible for Medicaid when previously many were uninsured or not Medicaid eligible.[7]

Health and Housing Correlations

- Chronically homeless individuals have higher morbidity and mortality rates than the general population.[8-12]
- Housing instability is associated with serious mental illnesses as well as many physical conditions, including obesity, cardiovascular disease, diabetes, HIV/AIDS, hypertension and other chronic conditions.[11] This population has high healthcare utilization, especially regarding emergency department usage.[13]
- Chronic homelessness is strongly correlated with substance use disorders, with as many as 60-80% of chronically homeless individuals with substance use disorders.[14, 15]
- In Massachusetts, although the homeless population comprises only 0.3% of the general population, they account for 5% of all fatal drug overdoses,[16] which is particularly noteworthy since Massachusetts has one of the nation's highest fatal overdose rates.[i][17]
- Recognizing the health and housing connection, states are implementing innovative strategies, such as New York using its reinvestment of state-only Medicaid savings for co-locating behavioral and health services in permanent housing congregate units,[18] and a Hawaii proposal would classify homelessness as a medical condition.[19]

Housing Instability Costs

Homeless populations, particularly the chronically homeless, are extremely costly to Medicaid due to high utilization of emergency departments and frequent hospitalizations.[20, 21] The 2015 Massachusetts Home and Healthy for Good report placed cost estimates for members experiencing chronic homelessness at nearly five times higher than the average Medicaid members.[22]

Current Services and Gaps

Various state and federal programs provide supportive housing services for populations experiencing, or at-risk-for, homelessness. However, many programs and funding streams are limited in scope or restricted to certain populations (such as Temporary Assistance to Needy Families (TANF), and Title IV-E Child Welfare funding.)

Massachusetts-funded supportive housing services include Department of Housing and Community Development (DHCD) programs and others, such as the Department of Mental Health (DMH)'s Homelessness Support Services for mentally ill homeless individuals and MassHousing's Tenancy Preservation Program (TPP) for individuals or families facing eviction related to a disability.

Massachusetts Behavioral Health Partnership (MBHP): Massachusetts' Primary Care Clinician (PCC) Plan's managed care behavioral health contractor. MassHealth members who do not select a Managed Care Organization are placed in the PCC/MBHP plan.

Medicaid pays for medically necessary supportive services that are used in partnership with separately funded housing resources to improve housing stability:

[i] For more data on the Massachusetts Opioid Epidemic, visit http://www.mass.gov/chapter55/

- Community Support Program for People Experiencing Chronic Homeless (CSPECH- See Figure 1), a program of the **Massachusetts Behavioral Health Partnership (MBHP)**, which provides critical Medicaid reimbursable supportive services for chronically homeless individuals
- Specialized Community Support Program (CSP) supportive services were added to the **MassHealth Managed Care Organization/CarePlus contract**, for members enrolled in the **Social Innovation Financing (SIF)** Program. SIF includes an interagency public-private social impact investment, separate from MassHealth, that provides housing.

The Managed Care Organizations (MCO) / Care Plus contract stipulates covered services under a capitated payment arrangement to MassHealth members under 65, who are not receiving Medicare, or are part of MassHealth's PCC.

CarePlus: CarePlus is a MassHealth benefit plan for adults 21 to 64 years old whose income is ≤133% of the federal poverty level, and who do not qualify for MassHealth Standard. Effective January 1, 2014, CarePlus is the MassHealth program under the Affordable Care Act's Medicaid Expansion.

Figure 1: CSPECH Description

beacon health options MBHP

Community Support Program for People Experiencing Chronic Homelessness (CSPECH)

WHAT: CSPECH is a specialized form of the Community Support Program, or CSP, level of care that pairs Medicaid-funded medically necessary support services with non-Medicaid-funded housing resources. Since 2005, it has been administered by the Massachusetts Behavioral Health Partnership (MBHP) for MassHealth Primary Care Clinician (PCC) Plan Members. These services have since been added to the MCO/CarePlus and Senior Care Options contracts. CSPECH provides non-clinical support services to help chronically homeless Members access and maintain permanent housing in the community.

POPULATION: CSPECH is designed specifically for chronically homeless individuals as defined by the federal Department of Housing and Urban Development (HUD). Individuals must be seeking imminent placement or currently placed in low-threshold, permanent supportive housing settings.

SETTING: Housing settings may be scattered site or congregate permanent supportive housing. Services may occur at housing settings, provider sites, or in the community. In congregate sites, case worker(s) may be embedded on-site.

SERVICES: Services are flexible with the goal of helping individuals to attain the skills and resources needed to maintain housing stability. Such services may include:

- Outreach and engagement
- Developing, utilizing, and updating Member service plan and safety plan
- Service coordination and linkages with formal and informal services and supports, including health care, benefits, and peer resources
- Assisting Members in accessing transportation
- Assisting Members to improve daily living skills and perform them independently
- Case management

HOW (Administered, provided and billed): CSPECH is administered through strategic partnerships with homeless/housing service providers. Services must be medically necessary and providers can bill for up to three months, on a daily case rate, before placement in housing, and then continuously as long as medically necessary.

AUTHORITY: In place via the Community Support Program of the Diversionary Service component of the MassHealth 1115 Waiver.

WHY: A recent evaluation showed CSPECH service receipt resulted in annual per person net healthcare savings of as much as $7,013.

Context

Federal

A June 2015 Centers for Medicare & Medicaid Services (CMS) Bulletin called for states to explore potential authorities to support chronically homeless population.[23] Additionally, many federal agencies such as Office of the Assistant Secretary for Planning and Evaluation (ASPE), HUD, United States Interagency Council on Homelessness (USICH), and others have offered guidance on integrating Medicaid with housing services.[23-25]

State

Although a pioneer in health reform, Massachusetts is not without its practical realities. Massachusetts was the first state to achieve near universal coverage following 2006 health reform, and has since aimed to constantly embark on innovative health policies through its 1115 Waiver.[ii] [26, 27] However, given the rising costs of health care, and MassHealth restructuring its delivery system to more accountable and integrated systems of care, the need to better serve the high-utilizing chronically homeless population is increasingly relevant to maintain Medicaid program sustainability.

While many permanent supportive housing models combine supportive services and housing, federal Medicaid dollars are prohibited for use on rent or housing production, Medicaid dollars can only be used for coverable services.

Solution: Permanent Supportive Housing

To address the persisting challenges of chronic homelessness, many researchers and policymakers point to the Housing First model that pairs low-threshold housing with supportive services. Housing First has proven effective at reducing health care costs, and improving health among chronically homeless individuals.[22, 28-32] Studies in Maine found savings up to $1,348/person, including major reductions in health care costs.[33] An Oregon study showed total Medicaid expenditure decreased by 12%, much attributed to reductions in emergency department use.[34] In addition to cost reductions, these models demonstrate improvements in health outcomes at the population and individual level.[11, 35] [36] Even more pointedly, a recent analysis of Massachusetts' CSPECH service program revealed net savings up to $7,013.[3]

Methods

This report represents a multi-pronged approach to exploring supportive services, that follows a rational-planning model for analyzing policy options, which involves (1) identifying existing resources for supportive services, (2) building a cost-effectiveness case, and (3) utilizing a polity-centered approach. A polity-centered approach places value on existing movements, leveraging political momentum, and forming relationships with key stakeholders to effect greatest change.[37] Further details on methods and contributors to this work can be viewed in the Appendices.

[ii] For more information on MassHealth reform activities, visit MassHealth Innovations at http://www.mass.gov/eohhs/gov/commissions-and-initiatives/healthcare-reform/masshealth-innovations/

1. Workgroup Convening and Medicaid Position

The CABHI-State Enhancement grant application secured the Medicaid Specialist position, with a mandate from Assistant Secretary Dan Tsai (Medicaid Director) to oversee an internal workgroup focused on exploring supportive services for chronically homeless members.

2. Policy Analysis

The Medicaid Specialist and Workgroup analyzed each policy option from the June 2015 CMS Bulletin: *Coverage of Housing-Related Activities and Services for Individuals with Disabilities*.[25]

3. Target Population and Service Utilization Estimates

To predict service needs with the total MassHealth managed care chronically homeless population, the chronically homeless individual population, service costs and offsets were estimated.

Analysis

This section consists of analysis specifically related to Massachusetts. Other states may choose similar routes, or evaluate the options explored that are included in the appendix.

Policy Options

While each option is briefly described, its highly recommended readers refer to documents[iii] that more thoroughly describe each.

[iii] *A Primer on Using Medicaid for People Experiencing Chronic Homelessness and Tenants in Permanent Supportive Housing*. 2014, ASPE. https://aspe.hhs.gov/system/files/pdf/77121/PSHprimer.pdf
A Quick Guide to Improving Medicaid Coverage for Supportive Housing Services. 2015, CSH. csh.org/wp-content/uploads/2015/05/A-Quick-Guide-To-Improving-Medicaid-Coverage-For-Supportive-Housing-Services1.pdf
Wachino, V., *Coverage of Housing-Related Activities and Services for Individuals with Disabilities*. 2015, CMS. https://www.medicaid.gov/federal-policy-guidance/downloads/cib-06-26-2015.pdf
Moses, K., et al., *Supportive Housing for Chronically Homeless Medicaid Enrollees: State Strategies.* 2016, CHCS. http://www.chcs.org/media/Housing-SGC-Brief_Final2.pdf
Arabo, F., et al, Housing as Health Care: A Road Map for States. 2016, NGA. ngahousingroadmap.cwsit.org/housingroadmap.pdf
Burt, M., et al. *Medicaid and Permanent Supportive Housing for Chronically Homeless Individuals: Emerging Practices from the Field*. 2014, ASPE. https://aspe.hhs.gov/system/files/pdf/77116/EmergPrac.pdf
Townley, C, et al. Strategies to Strengthen Health and Housing Partnerships Through Medicaid to Improve Health Care for Individuals Experiencing Homelessness. 2017. NASHP. http://nashp.org/wp-content/uploads/2017/07/Strategies-to-Strengthen-Health-and-Housing-Partnerships.pdf

The two options actively pursued by the CASH workgroup were:

- Managed Care Access
- Integration of Accountable Care Organization (ACO) reform

The Workgroup had most bearing on the former, which is discussed throughout the report. For the ACO reform, the Workgroup was minimally involved, offering housing-related service consultation.

Managed Care Access

Managed Care Entities (MCEs) have the flexibility within their capitation rates to add services beyond the basic Medicaid benefit package to address specific beneficiary needs and better manage services. As of September 2016, thirty-nine states and the District of Columbia had Medicaid managed care plans.[38] In Massachusetts, authority for increased access to services derives from long-standing language within the behavioral health section of each managed care contract, specifically **Community Support Program (CSP) services**, defined in the Massachusetts 1115 Waiver.

Accountable Care Organizations (ACOs) are entities designed to improve patient outcomes and control costs by shifting accountability for risk and quality to providers. As described the Massachusetts 1115 Demonstration, the Massachusetts ACO model uses Delivery System Reform Incentive Payment (DSRIP) resources to accelerate care delivery reform and implement new payment models, and facilitate access to social services to address health-related social needs. At least ten states began Medicaid ACOs through various mechanisms. [39, 40] One example of a Medicaid ACO impact, Hennepin Health of Minnesota, has reduced emergency department visits by 9% by using community service and housing specialists integrated within the medical system.[41]

Community Support Program (CSP) services are "[*a*]*n array of services delivered by a community-based, mobile, multi-disciplinary team of professionals and paraprofessionals. These programs provide essential services to Covered Individuals with a long-standing history of a psychiatric or substance use disorder and to their families, or to Covered Individuals who are at varying degrees of increased medical risk, or to children/adolescents who have behavioral health issues challenging their optimal level of functioning in the home/community setting. Services include outreach and supportive services, delivered in a community setting, which will vary with respect to hours, type and intensity of services depending on the changing needs of the Enrollee.*"

Managed Care Organizations (MCO) and Managed Care Entities: In Massachusetts, **MCE** is an umbrella term for entities providing comprehensive health care coverage to MassHealth members, that includes managed care organizations (MCOs), integrated care organizations (also known as One Care plans), Senior Care Options plans (SCOs), and the Primary Care Clinician (PCC) Plan's Behavioral Health contractor MBHP.

One Care is the Massachusetts demonstration health plan for Medicare-Medicaid enrollees age 21 through 64.

Investigated but not Pursued Further

Options investigated but not pursued further include:

- Other Managed Care Authorities: 1915(b) Waiver and Medicaid-Medicare Initiatives
- Health Homes
- Home and Community-Based Services, 1915(i) State Plan Amendment
- Targeted Case Management

- Rehabilitative Service Option
- Home and Community-Based Services, 1915(c) Waivers
- Community First Choice 1915(k) Waiver

Details of each reviewed option are included in the appendix for other efforts to consider as appropriate. For this particular analysis, in general, most appeared to require more time and resources to further explore than the project timeline allowed, and the benefits to the targeted population did not warrant continued pursuit. However, some states have utilized these options to varied extents, hence echoing the importance for states to perform their own individual analyses. For instance, the Rehabilitative Option has been recommended by Housing Policy Advocates,[42] and California and Minnesota have made great use of targeted case management to provide services within permanent supportive housing settings. See Table 2 for more details on these policy options.

Estimating Costs and Utilization

Any change to Medicaid requires assessment of potential costs and return on investment, thus warranting a clear financing argument that may involve leveraging existing resources and outlining a compelling argument for long-term savings. The first step is to calculate the target population in order to address service costs.

Calculating Costs of Recommended Service Expansion

Each state has its own budgetary decision-making process, but the costs of any new services must be known. Regarding this Massachusetts project, the steps outlined in Figure 2 were used to calculate estimated member and costs. The 2015 Point-in-Time Count of chronically homeless individuals in Massachusetts (1,411) was matched across the Commonwealth's managed care regions and multiplied by the estimated managed care membership (35%) and the annual per member service costs ($6,315). This resulted in an estimated 494 members in the Massachusetts Managed Care Organization/**CarePlus** contract, at about $3 million before accounting for additional factors (Table 1.) Additionally, the Senior Care Options (65+) population is estimated at approximately 121 members at $765,567/year.

Figure 2: Steps to Estimate Cost and Population

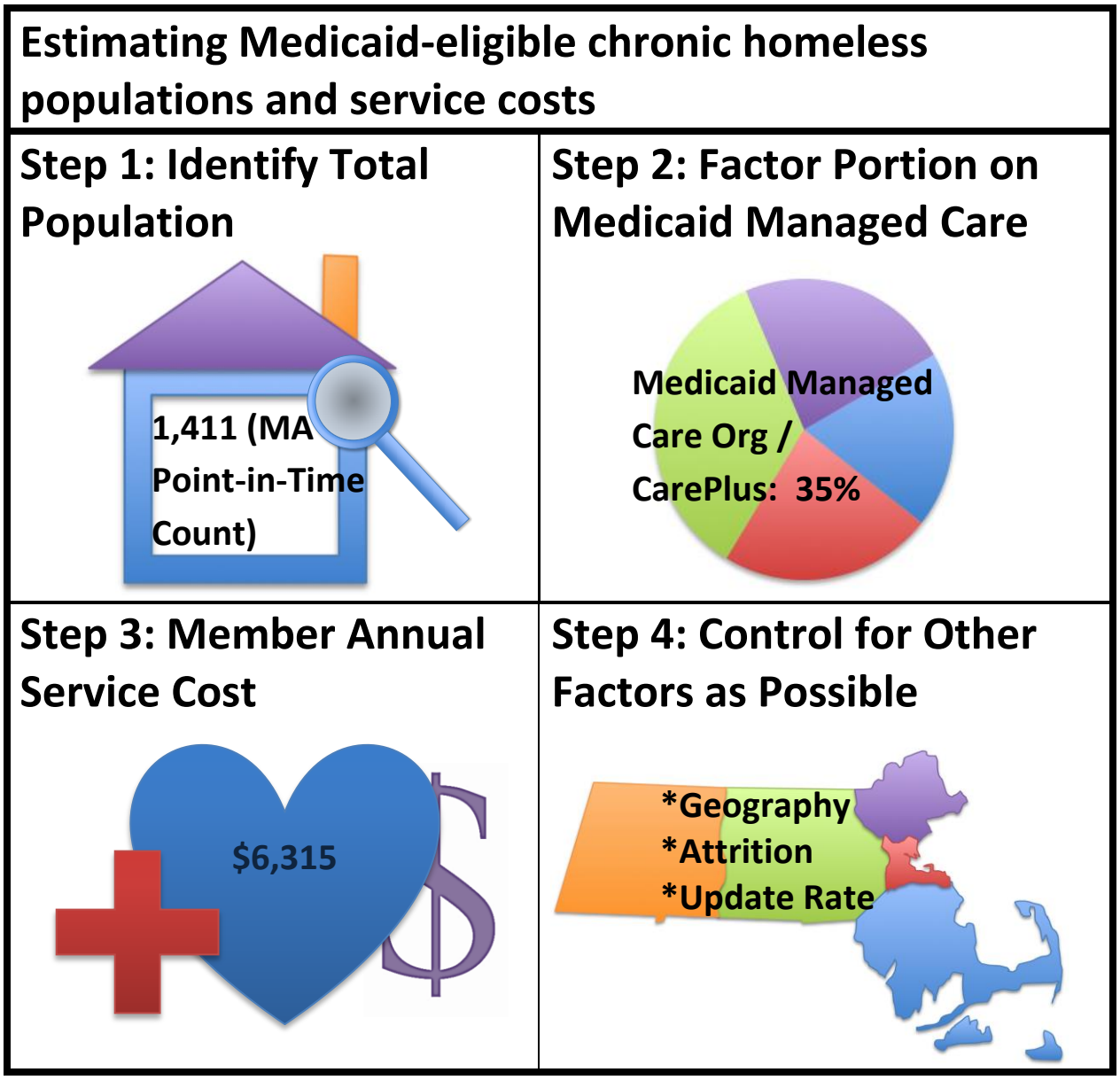


Table 1: Chronic Homeless Member and Cost Expansion Estimates

CSP in MCO/CarePlus Contract: Member and Cost Estimates						
Massachusetts MCO Regions	MCO Southern Region	Greater Boston Region	Central Region	Northern Region	Western Region	Totals
Chronically Homeless Individuals per MCO Region	194	809	52	210	147	1411
Estimated Proportion who are MCO members (35%)	68	283	18	73	51	494
Annualized cost per member ($6,315)	$ 427,683	$ 1,788,092	$ 114,933	$ 463,047	$ 324,907	$ 3,118,663

Notes
*2015 PIT Count used--CoC data overlayed with MCO regions--for CoCs spanning 2 MCO regions, the CoC's numbers were split between the 2 MCO regio
**MCO member estimate is based on City of Boston/Pine Street Inn tally of chronic homeless population in their region

Ensure Costs are Offset

For the analysis of this report, potential savings were anticipated due to evidence of reductions in health care expenses, particularly emergency department and inpatient care. Notably, a recent CSPECH evaluation further points to significant long-term net savings of this intervention.[3]

Lessons Learned

This CABHI Enhancement grant funded the administrative work necessary to coordinate these steps to undertake MassHealth's addition of CSP services for chronically homeless individuals within MassHealth managed care contracts: Managed Care Organization/CarePlus and Senior Care Options contracts. Steps toward addressing were as follows:

1. Identified Staff Resources: Medicaid Specialist with Medicaid work group
2. Targeted the Population: Chronically homeless individuals
3. Defined Service Model: Community Support Program for People Experiencing Chronic Homelessness (CSPECH)
4. Confirmed Authority: Medicaid managed care contracts and CSP behavioral health component of 1115 Waiver
5. Estimated Utilization and Costs: Estimated costs would be more than offset by savings achieved by reductions in other health care spending

Additionally, process steps completed to achieve this were the following:

1. Encouraged interagency and public-private collaborative efforts
2. Wrote managed care contract language (with review of legal and program Medicaid staff)
3. Developed performance specifications that included specific set of services, provider requirements and medical necessity criteria
4. Set billing details, including rate amount and billing code
5. Incorporated new service into managed care capitation rates

6. Drafted potential provider list
7. Communicated services with managed care plans
8. Facilitated roll-out of new service with providers and managed care plans

Recommendations

The following recommendations are based on the work of this project. Other states may gain from the recommendation general themes to advance their efforts. These insights may be useful to various stakeholders, especially state Medicaid offices.

Coordinate with Stakeholders

Health care and housing spheres have operated quite separately, and in fact vary widely in terms of financing, oversight and staffing. Even the language of health care and housing are varied. For instance, although the term "waiver" can refer to housing vouchers, which is quite different from Medicaid waivers as discussed in this report. State agencies and service providers in both health care and housing can educate each other on the holistic needs of homeless populations and work together on opportunities to better integrate supportive services and housing.

Designate Staff Resources

State Medicaid offices may consider designating point persons to coordinate efforts to address social determinants of health such as housing. Grants, such as the SAMHSA CABHI grants are a means to support such positions. Similarly, Medicaid managed care entities could consider specialists to address issues relating to housing within their MCE service package. For example, Tennessee requires each Medicaid health plan to employ a housing specialist to develop programs, policies, and procedures to increase resources for Tennessee Medicaid members.[43]

Maximize the Flexibility under 1115 Waiver and Managed Care Contracts

Managed care contracts and 1115 Waivers may be used to ensure supportive services are available to high-need populations including those who are chronically homeless. Managed care programs have opportunities to use their services to improve social determinants of their members by providing Medicaid supports and connecting to health and social resources. Refer to CMS guidance on what housing related activities and services are Medicaid reimbursable. .

Interagency Coalition to Address Service and Housing Needs

Interagency coalitions enhance the strength of a proposal through engagement of a wider stakeholder group. Such coalitions can be formed by identifying mutually beneficial goals (e.g. ending elder homelessness). Population-based approaches should be considered when appropriate. For instance, services for homeless families should consider family support, care coordination for children, and family reunification.

Perform Service and Assessment Gaps Analysis

Review of state and municipal resources can be an effective way to identify available supportive services for populations experiencing homelessness as well as to identify potential areas to more effectively utilize resources. The Medicaid Innovation Acceleration Program supports states in

cross-walking their services as part of their goal to foster additional community living opportunities for Medicaid beneficiaries.

Identify Evidence-Based Service Models

It is recommended to utilize evidence-based service models to maximize health outcomes. As previously discussed, evidence supports a strong rate of return for the CSPECH service program (Figure 1). Another model is Critical Time Intervention (CTI), which is a time-limited evidence-based practice that mobilizes support for society's most vulnerable individuals during periods of transition.[44] The 2013-2016 Massachusetts CABHI grant utilizes the MISSION model, also consisting of wraparound support services. For any model, an evaluation component will help measure utilization, costs, savings and other quality metrics.

Confirm Appropriate Medicaid Authority

States should consider the range of Medicaid options and delivery system approaches to support services that are most applicable to their respective delivery systems. Please see the Appendix for more details regarding existing Medicaid authority options.

Engage Service Providers

Many types of entities provide supportive services for homeless populations, from community health centers to homeless service organizations. Organizations seeking Medicaid reimbursement may need to make infrastructural shifts in how they coordinate and administer services—such shifts may include transitioning to become Medicaid providers independently, or affiliating with current Medicaid providers.[45, 46]

Conclusion

Evidence for supportive housing services for chronic homeless populations demonstrates the need for further action. Federal recommendations for expanded services including the CMS bulletin, *Coverage of Housing-Related Activities and Services for Individuals with Disabilities* highlight the various authorities by which Medicaid dollars could be leveraged for homeless individuals.[25, 47] Though Massachusetts ultimately required Medicaid managed care program contracts to leverage the Community Support Program component of the MassHealth 1115 waiver for chronically homeless individuals, other states may find different Medicaid options and flexibilities that best fit their needs.

Appendices

Definitions/Acronyms

Accountable Care Organizations (ACOs): As described in the Massachusetts 1115 Waiver, ACOs are provider-led organizations that are held contractually responsible for the quality, coordination and total cost of members' care.

The Annual Homeless Assessment Report (AHAR) Point-in-Time (PIT) Count: The Annual Homeless Assessment Report Point-in-Time Count is a HUD report to the U.S. Congress that provides nationwide estimates of homelessness, including information about the demographic characteristics of homeless persons, service use patterns, and the capacity to house homeless persons.

CarePlus: CarePlus is a MassHealth benefit plan for adults 21 to 64 years old whose income is ≤133% of the federal poverty level, and who do not qualify for MassHealth Standard. Effective January 1, 2014, CarePlus is the MassHealth program under the Affordable Care Act's Medicaid Expansion.

Centers for Medicare & Medicaid Services (CMS): CMS is a federal agency within the United States Department of Health and Human Services that administers the Medicare program and works in partnership with state governments to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance portability standards.

Chronic Homelessness:[48] The US Department of Housing and Urban Development (HUD) defines a ''chronically homeless'' individual to mean a homeless individual with a disability who lives either in a place not meant for human habitation, a safe haven, or in an emergency shelter, or in an institutional care facility if the individual has been living in the facility for fewer than 90 days and had been living in a place not meant for human habitation, a safe haven, or in an emergency shelter immediately before entering the institutional care facility. In order to meet the ''chronically homeless'' definition, the individual also must have been living as described above continuously for at least 12 months, or on at least four separate occasions in the last 3 years, where the combined occasions total a length of time of at least 12 months. Each period separating the occasions must include at least 7 nights of living in a situation other than a place not meant for human habitation, in an emergency shelter, or in a safe haven. Chronically homeless families are families with adult heads of household who meet the definition of a chronically homeless individual. If there is no adult in the family, the family would still be considered chronically homeless if a minor head of household meets all the criteria of a chronically homeless individual. A chronically homeless family includes those whose composition has fluctuated while the head of household has been homeless.

Community Support Program (CSP): Defined in the Massachusetts 1115 Waiver as "*An array of services delivered by a community-based, mobile, multi-disciplinary team of professionals and paraprofessionals. These programs provide essential services to Covered Individuals with a long-standing history of a psychiatric or substance use disorder and to their families, or to Covered Individuals who are at varying degrees of increased medical risk, or to children/adolescents who have behavioral health issues challenging their optimal level of functioning in the home/community setting.*

Services include outreach and supportive services, delivered in a community setting, which will vary with respect to hours, type and intensity of services depending on the changing needs of the Enrollee."

Continuums of Care: A CoC is a regional or local planning body that coordinates housing and services funding for homeless families and individuals. There are 16 CoCs in Massachusetts.

Cooperative Agreement to Benefit Homeless Individuals (CABHI): CABHI programs are competitive grant programs, jointly funded by the SAMHSA Center for Mental Health Services (CMHS) and the SAMHSA Center for Substance Abuse Treatment (CSAT). The CABHI programs support state and local community efforts to provide behavioral health treatment and recovery-oriented services, provided within a permanent supportive housing approach for people with: substance use disorders, serious mental illness, serious emotional disturbance, and co-occurring mental and substance use disorders.

Critical Time Intervention (CTI): CTI is a time-limited evidence-based practice that mobilizes support for society's most vulnerable individuals during periods of transition.

Delivery System Reform Incentive Payment (DSRIP): DSRIP programs are a new type of supplemental payment that provide incentive payments for hospitals and other providers to undertake delivery system transformation efforts, may involve infrastructure development and care innovation and redesign.

Dual Eligible (a.k.a.: Medicare-Medicaid enrollees): Medicare-Medicaid enrollees, also referred to as dual eligible beneficiaries, is the general term describing individuals who are eligible for both Medicare and Medicaid. One Care is the Massachusetts demonstration health plan for Medicare-Medicaid enrollees.

Housing First: Housing First is a homeless assistance approach that prioritizes providing people experiencing homelessness with permanent housing as quickly as possible – and then providing voluntary treatment as needed.

The United States Department of Housing and Urban Development (HUD): HUD is a Cabinet department in the Executive branch of the United States federal government overseeing home mortgage lending practices.

Interagency Council on Housing and Homelessness (ICHH): Massachusetts ICHH seeks to align the work of all state agencies in affirming the priorities of the Administration with substantive initiatives and progress in the development of permanent affordable housing supported by appropriate services which promote health, safety, well–being and self-determination for the citizens of the Commonwealth.

Massachusetts Behavioral Health Partnership (MBHP): Massachusetts' Primary Care Clinician (PCC) Plan's managed care behavioral health contractor. MassHealth members who do not select a Managed Care Organization are automatically placed in the PCC/MBHP plan.

One Care: One Care is the Massachusetts demonstration health plan for Medicare-Medicaid enrollees. (See Dual Eligible.)

Patient Protection and Affordable Care Act (PPACA or ACA): The ACA is a United States federal statute enacted in 2010 containing many provisions, including expansion of Medicaid to low-income adults 138% of the FPL.

Senior Care Options (SCO): SCO is a MassHealth managed care program for adults 65+.

Social Innovation Financing (SIF), or Pay for Success (PFS): PFS is an innovative contracting and financing model that leverages philanthropic and private dollars to fund services up front, with the government, or other entity, paying after they generate results. The Massachusetts Pay for Success Homelessness Initiative is a 2015-2019 interagency public-private social impact investment aiming to provide supportive services and housing for 500-800 chronically homeless individuals and/or high-frequency users of emergency services.

Social Security Act (SSA): An act to provide for the general welfare by establishing a system of federal benefits, and by enabling states to make more adequate provision for children, elderly, public health, and persons with disabilities.

Substance Abuse and Mental Health Services Administration: SAMHSA is the federal agency charged with improving the quality and availability of prevention, treatment, and rehabilitative services in order to reduce illness, death, disability, and cost to society resulting from substance use and mental health disorders.

Supportive Housing Services (SHS), a.k.a., Housing-Based Services and Supports for Supportive Housing Tenants: Can include pre-tenancy, transition to housing, tenancy maintenance and service linkage types of services. Supportive housing services incorporate services related to assessment, service plan development, referrals, monitoring and follow-up, medication management/monitoring, routine medical supports, entitlement assistance/benefits counseling, transportation, new tenant orientation/move-in assistance, outreach and in-reach services, independent living skills, job skills training/education, domestic violence intervention, support groups, respite care, individual counseling, discharge planning, and reengagement.[24]

Transitional Assistance: Non-recurring household set-up expenses that do not constitute room/board and may include: security deposits, set-up fees and deposits for utilities, essential furnishings, pest eradication, one-time cleaning, moving expenses, environmental adaptations, adaptive equipment, assistive technology; activities to assess need, arrange for and procure needed resources.

Methods – More Information

1. Workgroup Convening and Enhancement Position (continued): The MISSION: Housed MassHealth CASH Workgroup (**CA**BHI **S**upportive **H**ousing services) served as a point of reference advising on feasible Medicaid authorities to pursue, and served as a platform for forming the reports' policy recommendations. The workgroup benefited from a wide range of stakeholder collaboration (as evidenced in the Acknowledgements). The Medicaid Specialist position was the result of a strong partnership between representatives of MA Department of Public Health and Office of Medicaid (MassHealth). This relationship developed through existing collaborations at the state interagency level focused on ending homelessness and with MassHealth active participation on DPH's CABHI grant-specific Joint Interagency Task Force (JITF). With the advocacy of MassHealth Senior Policy Analyst Dorothée Alsentzer on the JITF, and her colleagues, Assistant Secretary (Medicaid Director) Dan Tsai became engaged and supportive, wrote a letter of support, and provided a space for the Specialist with the mandate to oversee an internal workgroup solely focused on developing supportive housing services. This collaboration understood the mutual goals of addressing improved health outcomes, housing stabilization and substance use disorder recovery support, and increasingly focused on the potential role of Medicaid. Further, this position became a resource to explore Medicaid-reimbursable supportive service options for this population and further encourage collaboration across state agencies regarding integrated housing supports.

2. Policy Analysis (continued): Analysis included literature review of each policy option outlined in the June 2015 CMS Bulletin on *Coverage of Housing-Related Activities and Services for Individuals with Disabilities*.[25] Respective authorities were reviewed, and key informant interviews were conducted with Medicaid content experts, other state agencies representatives, policy analysts, researchers, advocates, and healthcare and housing providers (see Acknowledgements). Each option was assessed for details on the financing, how appropriate it is to the population (chronically homeless individuals), other states with the option, and Massachusetts' context.

3. Population Estimations (continued): Analysis was based on the 2015 AHAR Point-in-Time (PIT) Count[4] and matched with the Massachusetts managed care regional coverage areas. Regional estimates of the distribution of managed care plan programs (e.g. MCO, One Care and SCO contracts) were based on 2016 City of Boston figures and the largest homeless-serving agency in New England (35% MCO, 25% Medicaid-Medicare enrollees), and multiplied by the annual service cost per person ($6,315)[iv]. ***Limitations:*** Other factors would influence service and cost estimates. Realistically, membership uptake would be staggered (i.e. not every eligible member would enroll on day 1) due to outreach needs, provider capacity and other issues. It is possible that the Boston figures, while representing a substantial proportion of the population, may not be generalizable across the Commonwealth. The PIT Count does not distinguish age (beyond youth), which would impact Medicaid programs with age ranges (such as under 65). To ensure offsets to costs, one explored avenue included considering maximizing existing state resources, as recommended by the 2016 Medicaid Innovative Accelerator Program Supporting Housing Tenancy Webinar Series.[v]

[iv] $6,315 is the annualized daily rate of CSPECH participation ($17.30/day multiplied by 365 days)
[v] More on revenue maximization can be found on IAP's website: https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/program-areas/community-integration-ltss/index.html

Analysis – More Information

Table 2a: Policy Options

Policy Option Analysis - Table 4A							
Option Information			**Option Analysis**		**Services: (X) if part of authority, dash (/) if service is limited**		
State Option (authority)	**Description**	**Known States w/ Program**	**Appropriateness to Targeted Population**	**Expansion Financing**	**General Supports (Across Tenancy Spectrum)**	**(Specific to) Pre-Tenancy + Tenancy Supports**	**Other Supports (Health+Non-Housing)**
Managed Care Authorities: 1915(b) Waiver (§1915b of the SSA); and Medicaid-Medicare Initiatives (§1115A of SSA as established via ACA §3021)	1915(b) Waivers are one of several options available to states that allow the use of Managed Care in the Medicaid Program, including granting more authority and ability to place Medicaid members in managed care. Medicaid-Medicare Dual Initiatives allow for managed care innovation for Medicaid-Medicare beneficiaries	37 states have a 1915(b) waiver; IA, MI, NC, NE OH, and WI have 1915(b) waivers that specifically cover housing-related services for individuals; 13 states have Medicare-Medicaid dual initiatives	With an aging chronic homeless population, and since the definition of chronic homelessness requires presence of a "disability", many chronically homeless are Medicare-Medicaid enrollees and may benefit from managed care	State responsible for its share of 1915(b) waiver; However Medicaid-Medicare Initiatives have had some funding	X Case Management Documentation Crisis/Safety Plan Service Linkage Education/ Training Home Modifications Peer Support	Transitional Assistance Household Goods Assistive Technology Housing Search Assistance Housing Utilitities/Fuel Other	Finance Coaching CORI mitigation Entitlement Linkage X Health Services Transportation X Other
1115 Waiver (§1115 of the SSA provides States flexibility to test new program changes, such as: expanding eligibility to individuals not otherwise Medicaid eligible, providing services not typically covered by Medicaid, and/or using innovative service delivery systems that improve care, increase efficiency, and reduce costs)	1115 allows for expanded coverage to specific groups to receive a tailored package of services even if they do not meet categorical eligibility criteria. Also authorized under 1115 authority are Delivery System Reform Incentive Payment (DSRIP) programs, and opportunities to implement accountable care organizations (ACOs)	Several states have CSP or similar language in state 1115 Waivers	1115 Waiver is quite flexible with opportunity to provides nonclinical community-based support services to Medicaid members	Although very flexible, must still be budget neutral	X Case Management X Documentation X Crisis/Safety Plan X Service Linkage X Education/ Training Home Modifications Peer Support	Transitional Assistance Household Goods Assistive Technology / Housing Search Assistance Housing Utilitities/Fuel / Other	/ Finance Coaching CORI mitigation X Entitlement Linkage X Health Services X Transportation X Other
Health Homes (State Plan Authority, §1945 of the Social Security Act; ACA §2703)	Health homes provide a comprehensive system of care coordination for individuals with chronic conditions	AL, CT, DC, IA, ID, KS, MD, ME, MI, MO, NC, NJ, NY, OH, OK, SD, VT, WA, WI, WV	Health Homes may be targeted to a broad range of chronic conditions, but likely cannot specifically target to chronically homeless population	90% enhanced federal match for first two years	X Case Management X Documentation Crisis/Safety Plan X Service Linkage X Education/ Training Home Modifications Peer Support	Transitional Assistance Household Goods Assistive Technology Housing Search Assistance Housing Utilitities/Fuel Other	Finance Coaching CORI mitigation Entitlement Linkage Health Services Transportation Other
HCBS 1915(i) State Plan Amendment (§1915i of the SSA, added from §6086 of the Deficit Reduction Act of 2005)	Home and community-based supports/services for members not necessarily requiring institutional level of care	LA, NV, CO, WA, WI, ID, CA, [no state has put forward a 1915i across chronic conditions]	Designed for needs-based populations who do not need institutional level of care, can relate to mental health or substance use but likely not homelessness specifically; also capping membership is prohibited	State responsible for its share of funding	X Case Management Documentation Crisis/Safety Plan X Service Linkage Education/ Training X Home Modifications Peer Support	Transitional Assistance Household Goods Assistive Technology Housing Search Assistance Housing Utilitities/Fuel Other	Finance Coaching CORI mitigation Entitlement Linkage Health Services Transportation X Other

Table 2b: Policy Options (continued)

Policy Option Analysis: Table 4B							
Option Information			**Option Analysis**		**Services: (X) if part of authority, dash (/) if service is limited**		
State Option (Authority)	**Description**	**Known States w/ Program**	**Appropriateness to Targeted Population**	**Expansion Financing**	**General Supports (Across Tenancy Spectrum)**	**(Specific to) Pre-Tenancy + Tenancy Supports**	**Other Supports (Health+Non-Housing)**
Targeted Case Management (TCM) (State Plan (42 CFR §440.169))	Interrelated services to individuals, eligible under the state plan in gaining access to needed medical, social, educational & other services	Most states use TCM in Behavioral Health component of their state plans (including MA); MN makes extensive use of TCM to provide case management services in supportive housing settings	TCM can be used to target specific groups by condition, region, but likely not homeless populations specifically	State responsible for its share of funding	X Case Management X Documentation X Crisis/Safety Plan X Service Linkage Education/ Training Home Modifications Peer Support	Transitional Assistance Household Goods Assistive Technology X Housing Search Assistance Housing Utilitilies/Fuel Other	Finance Coaching CORI mitigation Entitlement Linkage Health Services X Transportation Other
Rehabilitative Services Option (State Plan; §1905(a)13 of SSA)	Medical/remedial services recommended by a physician or other practitioner, for maximum reduction of physical/mental disability, restoration to functional level	All states have some form of Rehab Services, but vary in extent medicalized	Intended for members with a physical or mental disability; states can offer broad range of mental health & substance use services, or physical health rehab services to individuals in the community	State responsible for its share of funding	X Case Management X Documentation X Crisis/Safety Plan X Service Linkage Education/ Training Home Modifications X Peer Support	Transitional Assistance Household Goods X Assistive Technology X Housing Search Assist. Housing Utilitilies/Fuel Other	Finance Coaching CORI mitigation Entitlement Linkage X Health Services Transportation Other
Home & Community-Based Services Waivers 1915(c) (§1915(c) of the SSA)	Home and community-based supports/services for members requiring "facility level of care"	Most states have at least one 1915c waiver	Facility-level of care and specific condition requirement means these waivers could only reach some chronically homeless. Note, individuals residing in an institution for 90 days or more do not qualify as chronically homeless	State responsible for its share of funding	X Case Management Documentation Crisis/Safety Plan Service Linkage Education/ Training X Home Modifications Peer Support	/ Transitional Assistance X Household Goods Assistive Technology Housing Search Assistance Housing Utilitilies/Fuel Other	Finance Coaching CORI mitigation Entitlement Linkage Health Services X Transportation Other
Community First Choice - 1915(k) (State Plan; §1915(k) of SSA, established under ACA)	Attendent services/ supports and transitional assistance for Medicaid enrollees with disabilities at Facility-level of care	CA, MD, MT, OR, TX	Facility-level of care and specific condition requirement means these waivers could only reach some chronically homeless. Note, individuals residing in an institution for 90 days or more do not qualify as chronically homeless	CMS provides 6% increase to a state's Enhanced Federal Medicaid Assistance Percentage for these services	Case Management Documentation X Crisis/Safety Plan Service Linkage Education/ Training Home Modifications Peer Support	X Transitional Assistance X Household Goods Assistive Technology Housing Search Assistance X Housing Utilitilies/Fuel Other	Finance Coaching CORI mitigation Entitlement Linkage X Health Services Transportation X Other: Rep Payee

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