



ISSUE BRIEF

Developing Housing and Health Collaborations

Opportunities and Challenges

Brenda C. Spillman
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Josh Leopold

Eva H. Allen

Pamela Blumenthal



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Introduction

The Affordable Care Act (ACA) and other health care payment and delivery system reforms have provided new or expanded opportunities at the state, local, and organizational levels to forge collaborations between health care and housing providers. The hope is that collaborations will result in fewer people experiencing homelessness or preventable institutional living; a more stable tenant population for housing providers; a better platform for effective delivery of health care; and better care, better outcomes, and lower health care costs for vulnerable populations. This brief highlights key issues for collaborations and the ways in which programs are addressing them. We draw on an environmental scan of health and housing system collaborations facilitated or improved by the ACA and related reforms,¹ discussions with leaders of three programs that are integrating housing and health care in different ways, and conversations with national policy experts. The three programs we examined to learn more about opportunities and challenges in health and housing collaborations are the New York Medicaid Redesign Team (MRT) Supportive Housing Initiative; Housing with Services (HWS) in Portland, Oregon; and Integrated Care for the Chronically Homeless in Houston, Texas. Table 1 shows key features of each program.

Through the literature review and interviews, we identified several challenges to the successful integration of health and housing and essential components to overcome these challenges. Dedicated leadership and commitment of key players to shared goals were recognized as important ingredients in bringing collaborations to life. A thoughtful and deliberate planning process, which includes needs assessment and appraisal of existing resources and available opportunities, improves the viability of a project. Patience is critical. It takes time for housing and health stakeholders to understand each other's resources and limitations and determine appropriate roles and responsibilities. Successful partnerships require not only education and training for all parties, but also mutual trust and cooperation.

Program financing is perhaps the foremost question for policymakers and practitioners considering collaborations. We have identified several resources that states, health care payers, and housing agencies can use to support housing and housing-related services, as well as limitations and barriers with implications for state and national policies. Medicaid, the joint federal-state health insurance program for people with few economic resources, often is an important element in funding services required for successful collaborations.

TABLE 1

Key Features of Selected Housing and Health Collaborations

	New York MRT Supportive Housing Initiative	Housing with Services	Integrated Care for the Chronically Homeless
Brief description	A multipronged approach that connects vulnerable populations to health care, housing, and related supports through implementation of Medicaid Health Homes, a comprehensive, integrated model of care for people with chronic disease; investment of state Medicaid savings into construction of supportive housing and rental subsidies; and pilot grants to test new supportive housing models.	A limited liability corporation of nine partners, including housing providers and health and social services providers, established to coordinate health care and social services for low-income seniors and individuals with disabilities residing in federally subsidized housing.	A collaboration among a health center, a homeless services provider, and a housing provider to bring integrated health care and social supports to individuals who are experiencing chronic homelessness and are frequent users of hospital emergency services.
Geographic scope	New York State	Portland, Oregon	City of Houston and Harris County, Texas
Partners	State agencies, including the Department of Health, the Offices of Temporary and Disability Assistance, Mental Health, People With Developmental Disabilities, and Alcoholism and Substance Abuse Services; the AIDS Institute, the Division of Long Term Care, and Homes and Community Renewal (the state housing agency).	<i>Housing:</i> Cedar Sinai Park, Home Forward (Housing Authority of Portland), REACH Community Development <i>Insurance:</i> CareOregon <i>Service providers:</i> Asian Health and Service Center, Cascadia Behavioral Healthcare, Jewish Family and Child Service, Lifeworks Northwest, Sinai Family Home Services	The Houston Health and Human Services Department, the Houston Housing Authority, and the City Housing Department. Lead providers are Healthcare for the Homeless–Houston Health Center, SEARCH Homeless Services, and New Hope Housing, Inc.
Target population	High-need, high-cost Medicaid beneficiaries, including those experiencing or at risk for homelessness, and residents in nursing facilities.	Low-income seniors and individuals with disabilities residing in HUD-subsidized housing who opt in to the program.	Individuals experiencing chronic homelessness with at least three ED visits over the past two years.
Services	Care coordination and links to services and supports including housing; rental subsidies; tenancy advocacy; supportive services, which may include case management, counseling and crisis intervention, employment and vocational assistance, educational assistance, life skills training and building security services.	Health care, mental health and substance abuse counseling, prescription medication management, wellness services, food insecurity prevention and nutrition counseling, social engagement program. Health care navigators and care coordinators help link residents to needed services.	Primary care, substance use and behavioral health counseling. Community health workers assist in managing participants' health needs. Clinical case management is provided in a supportive housing environment.
Funding	State share of Medicaid redesign-related savings, bonds for construction, Health Home program.	LLC partners' equity contributions, SIM grant, and grants from foundations and private organizations.	Medicaid 1115 waiver DSRIP payments, HRSA Health Center Program, and various grants. Rental subsidies are provided through the Houston Housing Authority.

Both policy and program experts emphasized the importance of data for designing effective interventions, enabling coordination across health and housing systems, and documenting program impacts to support the business case for collaboration. Inadequate infrastructure to integrate information systems and rules and regulations that limit or are perceived to limit sharing of health data are often cited as barriers to collaborations and opportunities where policy changes could be effective.

How Challenges Become Opportunities

In the following sections, we examine key challenges to collaborations between health and housing providers and strategies that programs and initiatives used to address them.

Collaboration Is Hard to Do

Leadership and Shared Vision Are Needed to Build Relationships between Partners

The ACA created new opportunities and incentives for health care systems to address social determinants of health including housing, but six years after its passage, states and communities are struggling to figure out how to take advantage of these opportunities. Housing and health systems have separate bureaucracies, regulations, and funding. Federal rules and regulations can create barriers to collaborations between housing and health care providers, and in the current dynamic health care environment, providers face many competing priorities. However, the collaborations we examined show that strong leadership and shared vision can overcome these obstacles.

Many of the policy experts we interviewed felt that the implementation of relevant ACA provisions has not yet made serious inroads into addressing housing and other social determinants of health but has raised awareness within the health care community about their importance. For example, the ACA provided financial incentives for states to expand Medicaid eligibility to all individuals with incomes at or below 138 percent of the federal poverty level (FPL). In the 32 states that have expanded Medicaid eligibility to date, millions of additional low-income people, many of whom are experiencing homelessness or have unstable housing situations, are newly covered.² As a result, an increasing number of state Medicaid agencies, Medicaid managed care organizations (MCOs), accountable care organizations (ACOs), and other payers see the value of connecting these new beneficiaries to stable housing as a way to improve care and reduce costs (box 1).

However, several of the experts believed that the health care sector's increased awareness of housing has not translated into new resources. One reason is that public funding for health care is highly regulated, with eligible uses restricted to specific services for specific populations. For example, federal Medicaid funds cannot be used to pay for room and board, and federal regulations create disincentives for MCOs to invest in housing and other social supports.³ The Delivery System Reform Incentive Payment (DSRIP) program, available to states under Medicaid Section 1115 waivers, gives substantial funding to providers to transform the way they deliver care, but the agreements sometimes restrict payments for social services such as housing supports. For example, New York's DSRIP agreement limits the amount of funding that can go directly to nonclinical providers to no more than 5 percent.⁴

BOX 1

Key to Health Care Terms

Managed care organizations (MCOs) are health care delivery and administrative entities that provide and manage health benefits for members. Increasingly, state Medicaid agencies are contracting with MCOs to provide and coordinate health care and additional services for a PMPM (capitation) payment.

Accountable care organizations (ACOs) are a payment and delivery model in which provider networks coordinate and integrate health care services and are financially responsible for health outcomes of the populations served under a global budget. ACOs may share savings achieved (one-sided risk), or they may also be liable for any budget overruns (two-sided risk).

Value-based payment (VBP) rewards health care providers for meeting specific quality outcomes. The goal is to provide incentives for the quality, rather than the volume, of care provided. VBP affects public and private payers, MCOs, hospitals, and new care models, such as ACOs. VBP usually includes some level of provider risk-sharing and may allow more flexibility to address nonclinical factors that can affect health outcomes.

Section 1115 demonstration waivers allow states to test Medicaid program innovations and broader-based reforms, for example, by expanding eligibility to individuals who are not otherwise Medicaid-eligible or by providing services not typically covered by Medicaid. Waivers are initially approved for five years and can be amended or extended.

Note: PMPM = per member per month.

In addition to the funding restrictions, experts believe that lack of cross-sector relationships and capacity constraints have limited the ACA's impact in providing incentives for the health care system to

address housing and other social determinants of health. Programs like DSRIP and the creation of ACOs, which encourage integrated, whole-person care (WPC), are typically led by large hospital networks. Housing providers and other community-based organizations do not necessarily have close relationships with these hospital networks and may not be at the table when decisions are made about where to invest resources. In New York, for example, only one of the 44 projects eligible for DSRIP funding is housing-related. Value-based payment structures (box 1) for ACOs and other provider systems may provide incentives and flexibility to address social determinants of health. However, many health systems are still grappling with how to effectively collaborate with nonmedical providers. In Oregon, most coordinated care organizations (CCOs, Oregon’s version of ACOs) focus their community health improvement efforts on chronic disease management and similar activities within their comfort zone, as opposed to housing or other social determinants of health.⁵

Though health care stakeholders welcome the idea of connecting their patients to housing, it is one of many nonclinical supports competing for health care investment. Those involved in the health care system, including state Medicaid agency staff, managed care plan administrators, and local health care providers, also face a steep learning curve in understanding the affordable housing landscape and how it relates to their mission. As one expert noted, health care providers are currently absorbed with how to best coordinate with other providers within the health care system itself: “I don’t see the health care system being able to see beyond the 85,000 things they are trying to do at once to lift their heads up and understand this [housing].”

Despite these barriers, some states, counties, and provider networks have used aspects of the ACA and other health care reforms to integrate housing and health services for vulnerable populations. Though the three programs highlighted in this brief—New York’s MRT Supportive Housing Initiative, Houston’s Integrated Care for the Chronically Homeless, and Portland’s Housing with Services—are very different from each other, they all have strong leadership and stakeholder commitment to make the collaboration work.

In New York State, the Medicaid redesign was led by Governor Cuomo, who had previously served as Chairman of the New York City Homeless Commission and Secretary of the US Department of Housing and Urban Development (HUD). These experiences gave him a unique perspective on the importance of investing in housing to improve health care access and reduce costs. With support from key stakeholders, Governor Cuomo issued an executive order to set up the MRT under the state’s Medicaid Section 1115 waiver and to develop a plan for improving the quality of care and slowing down escalating health care costs in the state’s Medicaid program.⁶ As part of the MRT Initiative, the state convened a supportive housing workgroup charged with assessing the availability of supportive housing

and determining how to leverage existing resources and new investments to increase its availability for those who need it most. Workgroup recommendations are submitted to the state agencies responsible for turning the recommendations into actionable policies and programs.

Houston's Integrated Care for the Chronically Homeless model originated in 2012, when then Mayor Annise Parker made a public pledge to end chronic and veteran homelessness by expanding the availability of supportive housing.⁷ This spurred a community-wide stakeholder engagement process uniting the mayor's office, the health department, and housing agencies and advocates in the effort to address homelessness by providing quality permanent supportive housing (PSH) prioritized based on individuals' need. With help from the Corporation for Supportive Housing (CSH), stakeholders identified a funding opportunity in the state's Medicaid Section 1115 demonstration waiver that would cover health and supportive services coordination, and the Houston Housing Agency created an administrative preference for individuals eligible for the program, giving them prioritized access to housing vouchers.

Portland's HWS initiative began in 2010 with the leadership and vision of David Fuks, then CEO of Cedar Sinai Park, a Jewish community-affiliated nursing home, assisted and independent living nonprofit, and affordable housing provider. After Cedar Sinai Park acquired four apartment buildings with 400 units of federally subsidized rental housing for low-income seniors and people with disabilities, Fuks realized the need to connect these residents to services to maintain their quality of life and avoid placement into institutional care. Fuks brought together more than 20 community stakeholders, ranging from small nonprofit service providers to Portland's housing authority and Oregon's largest Medicaid health insurer (CareOregon). Their efforts attracted funding from various sources, including the Centers for Medicare & Medicaid Services (CMS), private foundations, CCOs, and insurance providers, and led to an extensive planning process culminating in the establishment of HWS.

The policy and program experts we talked to stressed the importance of high-level leadership in making these collaborations work. Forging successful partnerships between housing and health care systems takes time and patience. Without strong and committed leadership, it is difficult to get the critical partners to the table and keep them there. One respondent noted that without solid leadership, these collaborations "fall apart very quickly." National advocacy and advisory groups can also be instrumental in supporting the development of partnerships. In New York and Houston, CSH has provided critical guidance in developing and implementing supportive housing programs (SHPs). In 2010 and 2011, Cedar Sinai Park participated in a national health and housing learning collaborative led by LeadingAge and Enterprise Community Partners and in a local health and housing learning collaborative organized by Enterprise.⁸

We Can't All Be New York

Collaboration Can Be Successful at the State, County, and Local Levels

Through its MRT Supportive Housing Initiative, New York State has pursued a comprehensive and systematic approach to increasing access to supportive and affordable housing for vulnerable populations. No other state has invested as much of its state funding into housing, but that has not prevented other housing and health care collaborations from succeeding at the state, county, or city level.

New York's MRT housing efforts grew out of extensive Medicaid reform that began in 2011, with the goals of improving quality of care, reducing avoidable hospital use, and curbing Medicaid cost growth. MRT reforms include a global spending cap on state Medicaid expenditures, a 2 percent Medicaid rate cut to all services, and the implementation of Medicaid Health Homes, an integrated care model designed to improve care management and coordination for the high-cost, high-need Medicaid beneficiaries responsible for the majority of state Medicaid spending.⁹ New York has invested the state portion of Medicaid savings generated by the MRT reforms into the construction of new supportive housing units, rental assistance, and services to support people in housing. As part of the MRT Supportive Housing Initiative, the state also developed a range of pilot projects to test innovative supportive housing models of care for specific populations. The Supportive Housing Health Home Pilot provides funding for rental subsidies and on-site community-based services for Medicaid beneficiaries who qualify for the health home program and are experiencing homelessness or are unstably housed. The purpose of this pilot is to identify best practices for supportive housing providers to collaborate with health homes. Other MRT supportive housing pilots include a project that subsidizes rent and services for people with physical disabilities who wish to live in the community, a project enabling low-income seniors to remain in the community through home modifications and supportive services, and a pilot targeting people transitioning from psychiatric hospitals to community settings. New York has one of the largest Medicaid programs in the country, and its sweeping redesign efforts have produced substantial savings, allowing the state to invest \$503 million into its SHPs since 2011. In July 2015, CMS approved the New York State Roadmap for Medicaid Payment Reform, which outlined plans to move 80 to 90 percent of managed care payments to providers from fee-for-service to VBP by 2020.¹⁰ As part of the payment reform, the state envisions that VBPs will incentivize providers to address social determinants of health, and it is exploring ways to capture savings that will accrue in other public sectors from social determinant interventions (e.g., reduced recidivism).

New York's initiative is exemplary, but integrating health with housing is possible and can be successful on a smaller scale and with far fewer resources. Integrated Care for the Chronically Homeless is a city- and county-led program initiated by Houston's mayor's office and health and human services department, in close collaboration with the Houston Housing Authority and the city's housing department. The program brings together federally qualified health centers (FQHCs), a homeless services provider, and a housing provider to offer supportive housing and integrated health care and clinical case management to individuals experiencing chronic homelessness who are frequent users of emergency department (ED) services. Though Texas did not expand its Medicaid program, the state created an avenue through which local governments could supply funding and be eligible to receive federal matching funds under the Medicaid Section 1115 waiver. As part of the waiver, the DSRIP program creates flexible funding that can be used to support innovative models of care aiming to improve health outcomes and quality of care and bring down costs. Houston's health department seized this opportunity and submitted a successful application for DSRIP funds to support the development and implementation of the Integrated Care for the Chronically Homeless initiative. Its vision is to end homelessness in Houston and Harris County, but the project started small, offering services to 200 people, with the understanding that if the program is successful in meeting performance benchmarks tied to DSRIP, subsequent pay-for-performance payments—and, potentially, multipayer participation—would allow for program expansion.

Houston's DSRIP program was just one of three main components of the Integrated Care for the Chronically Homeless program. The affordable housing developer and property manager provides the apartments, and the Houston Housing Authority provides the rental subsidies. By choosing FQHCs as lead providers, the initiative benefits from Health Resources and Services Administration (HRSA) funding to health centers, as well as FQHCs' experience in serving vulnerable populations and established relationships with homeless service providers. By encouraging cross-sector collaboration, being strategic about existing community resources, and taking advantage of health reform opportunities, Houston developed a highly integrated model of care that features a robust clinical team and comprehensive service package to improve the health and well-being of program participants.

Portland's HWS is another local, small-scale, and successful integration of health care with housing. HWS aims to improve health, reduce health care costs, and promote social inclusion for low-income seniors and people with disabilities living in federally subsidized housing by improving access to and coordinating health and supportive services. This project grew from the efforts of a single housing provider with four buildings into a collaboration of nine partner organizations serving 11 buildings. A thorough planning process led to development of a unique delivery model, where each partner assigns

staff to deliver resident services including health navigation, case management, and mental health services. This approach streamlines service delivery and, according to program staff, is less expensive than a per member per month (PMPM) capitated rate approach and more efficient to administer. Ten out of 11 buildings are located in or near downtown Portland, so clients live near each other as opposed to being scattered throughout the city; this geographical proximity facilitates efficient delivery of services. HWS benefited from established relationships with a range of community-based nonprofit agencies that were already serving the residents in participating buildings, and the program hopes to benefit from financing flexibility made possible by Oregon's implementation of CCOs, which have incentives to pay for activities and services not traditionally covered by Medicaid. Additionally, the project was able to tap into Oregon's State Innovation Model (SIM) grant funding from CMS, awarded to the state to develop and test innovative delivery system and payment models.

Despite challenges and limited resources, health and housing collaborations across the country have developed and prospered by making good use of existing relationships, infrastructure, and financing opportunities. Sometimes new collaborations are born out of unique circumstances, as in Louisiana. Widespread homelessness after Hurricane Katrina and a massive infusion of funds for recovery efforts led to the establishment of the Louisiana Housing Authority, which partnered with the state Medicaid agency to develop a statewide PSH program that provides health care, supportive housing, and other social services and supports to individuals and families with disabilities. Louisiana has relied on Medicaid state plan mental health rehabilitation services, 1915(c) home and community-based services waivers, and (initially) 1915(i) state plan services to provide supportive services.¹¹ Housing is developed through low-income housing tax credits (LIHTC) for housing developers and housing subsidies for residents. Congress directed 3,000 additional federal housing vouchers to Louisiana in 2008 (box 2), which kick-started the program.¹²

The Housing for Health initiative at the Los Angeles County Department of Health Services (DHS) is another example of a locally led and locally funded initiative to end homelessness. DHS is an integrated delivery system, operating four hospitals and a network of clinics throughout Los Angeles County and dedicated to improving access to supportive housing for people who have complex physical and mental health conditions and are experiencing chronic homelessness. The underlying motivation for Housing for Health, which has a dedicated division within the agency, is that investing in housing paired with intensive case management saves the county money by reducing spending on emergency medical services, repeat hospitalizations, and nursing home stays. DHS has engaged a wide range of partners in the community to develop housing options and a supportive services package, including case management providers, public housing authorities (PHAs), housing developers, and foundations. In

addition to relying on project-based vouchers, DHS invested \$14 million into the flexible housing subsidy pool, which provides supportive housing rental subsidies.^{13,14}

BOX 2

Key to Housing Terms

Federal rental assistance programs include the Section 8 housing choice voucher program, Section 8 project-based rental assistance, and public housing. HUD distributes funding to local PHAs and private property owners. PHAs can create waiting list preferences for specific populations (e.g., people who are homeless).

Permanent supportive housing (PSH) combines a permanent rental subsidy and supportive services for people who are experiencing homelessness and/or have serious and long-term disabilities. Services include case management to help tenants find and maintain housing and connect to community-based services including health care, transportation, employment and education, and eligible benefits.

The **low-income housing tax credit (LIHTC)** program provides tax credits to housing developers and property managers to help finance construction or rehabilitation of affordable rental housing. Federal regulations require that at least 20 percent of units in tax-credit properties be reserved for low-income renters. States can establish additional requirements, such as setting aside a portion of units for people with disabilities.

Note: PHA = public housing authority.

We Speak a Different Language

Planning and Patience Are Critical for Success

Cultural challenges to integrating housing and health care systems were a recurring theme in our interviews and in the literature. Health care, housing, and social service providers operate in different worlds. They have different priorities, incentives, and funding streams; are guided by different regulations; and answer to different authorities. Providers traditionally have operated in silos and know little about each other, even when they serve the same clients. Breaking down silos takes time, effort, and commitment from all parties. This process begins in the planning stages of a new initiative and continues throughout program implementation, as new developments and unexpected challenges arise that may require program adjustments. Stakeholders must reach agreement on a wide range of issues, from defining the program mission and partnership structure to developing a service package and staff

roles and responsibilities, to delineating day-to-day operations. A careful and deliberate planning process can facilitate learning and relationship building and minimize conflicts.

The importance of patience in collaborations is exemplified by the planning process for the HWS initiative, which went through nearly two years of planning meetings before launch as well as ongoing meetings of program partners to implement and refine the model. The planning group began by examining various service models and payment structures that might facilitate effective collaboration of health, housing, and services providers in the affordable housing setting. As the key components of a delivery model emerged, nine organizations decided to form a limited liability corporation (LLC), with equity contributions required from each partner as a condition of participation in the LLC. As a legally binding partnership, the LLC allowed partners to state clearly the terms of engagement, including the governance model, financial commitments, liability protection, and risk-sharing structure. The LLC itself is an administrative oversight body, staffed by a part-time project director and a full-time operations director who provide administrative support, program development, and service coordination oversight and support. Each partner organization assigns staff to the HWS program to provide services to program participants. In addition to LLC partners, HWS entered into an interagency agreement with about 15 other community-based organizations that also serve the program participants. The interagency agreement defines a common mission and each provider's specific role, details processes for service coordination, identifies single points of access, and sets up cross-agency referral protocols to allow for efficient delivery of services.

Much time and effort were also devoted to developing a service package and staffing model. A key component of the service package involved development of contracts with Islamic Social Services, Jewish Family and Child Service, Catholic Charities, and the Asian Health and Service Center to support outreach, education, and delivery of culturally specific services to the diverse community of residents served by HWS. This process was guided by the Resident Advisory Council and a survey of residents in the participating buildings to determine what services they need and who is best suited to coordinate or deliver the services. The council, which includes resident representatives from each of the buildings, participated in development of the services delivery model, design of the initial needs assessment and survey instruments, and outreach and education. Over time, the council has assumed a leadership role in the development and implementation of site-based food pantries, a food distribution program, resident volunteer services exchange, and a community inclusion network, and it continues to provide ongoing oversight and feedback on the program.

Similarly thoughtful planning processes took place in New York and Houston. New York established the MRT Supportive Housing Workgroup to bring together key stakeholders, including service

providers, developers, advocates, and state agencies, to develop recommendations for increasing access to affordable and supportive housing. Some of these recommendations were informed by needs assessment studies to better understand who should be prioritized for new supportive housing units.¹⁵ For example, a study of Bronx health homes, conducted jointly by CSH and the Bronx Health and Housing Consortium, revealed that about 28 percent of health home enrollees experiencing homelessness were families. The study also showed that many individuals experiencing chronic homelessness were aging, with deteriorating health.¹⁶ These findings were taken to the MRT workgroup and led to allocation of more MRT supportive housing units for families and implementation of pilots targeting health home enrollees and seniors specifically.

Houston conducted a community needs assessment to determine the target population for supportive housing and what services should be covered through Integrated Care for the Chronically Homeless. The planning group also conducted a literature review and visited other programs with similar focus to understand best practices for providing integrated care in supportive housing. Once the delivery model was defined and providers selected through a competitive bidding process, months of discussions took place among the selected providers to work out how to operationalize the program and coordinate with each other. According to a program official, aligning the health center with the homeless service provider was not nearly as difficult as integrating with the housing provider. Some of the challenges stemmed from the housing staff's lack of experience serving people with severe physical and mental health conditions and from frustration on the part of the housing provider about not being able to access protected health information. Other challenges related to the delineation of roles and responsibilities. For example, the housing provider requested that clinical case managers conduct monitoring visits with clients to see how clean and well-kept their apartments were. The health center and service provider were resistant to this idea because they considered it a housing management issue and unnecessary policing. But it turned out that many program participants needed assistance in learning how to maintain their apartments as part of the responsibilities of tenancy, and it was valuable for case managers to help them build or rebuild these skills and make sure that their clients understood what was required to maintain their housing.

The success of any new initiative depends partly on how well providers on the ground turn ideas into action. It takes time for providers to fully embrace new systems, set up structures and processes, and work out kinks. Often, reality differs from the initial vision, or unforeseen challenges arise, requiring reevaluation and programmatic changes, which can be demanding for program executives and frontline staff. Particularly when organizations that have never worked together are required to coordinate and work as a team, establishing good communication habits and building trusting relationships are crucial

to keep things going. In Houston, the three provider agencies responsible for service delivery began meeting regularly throughout the planning process; they continue to hold monthly meetings for collaboration leaders and weekly meetings for frontline staff. To encourage team-building, the agencies sponsor quarterly lunches for all staff.

In addition to the establishment of communication channels, education, training, and technical assistance are essential to implementing new programs and taking on new roles and responsibilities. Some experts argue that without appropriate training and support, providers may have a hard time meeting the program objectives. Program staff indicated that the initial success of New York's health homes was limited because care coordinators needed additional training on how to connect to social services like housing. Additional upfront investment in training would have been helpful. The lack of training may have contributed to high turnover among care coordinators, which hurts relationships with partner organizations. An initiative can improve its chances for success by providing adequate education and training to help frontline staff carry out their mission more efficiently.

Funding Is Fundamental

A Mix of Public and Private Sources Is Common

In addition to leadership and planning, successful collaborations require money. The initiatives we examined use a variety of funding sources to provide health care services and care management. These include HRSA grants for FQHCs and Healthcare for the Homeless programs, Medicaid health homes, CMS SIM grants, HUD SHP grants, state and county funds, philanthropic support, and in-kind contributions of staff time. The greatest opportunity for funding to support services in housing and health care collaborations is reimbursement through Medicaid. Even though the federal statute prevents the federal share of Medicaid funds from being spent on capital and operational costs to build or rehabilitate housing, room and board, or regular expenses such as utilities and food, Medicaid may cover benefits that help eligible populations find and maintain independent housing.

In June 2015, CMS released an informational bulletin describing housing-related activities and services for which the federal share of Medicaid reimbursement may be used (box 3).¹⁷ The bulletin clarified that for individuals with disabilities receiving services under state Medicaid plan benefits or various waiver authorities, a wide array of supports to help people transition into community-based housing and sustain their tenancy may be eligible for federal reimbursement. The policy experts we interviewed were split on the impact of the CMS bulletin. Some experts were not aware of the guidance

or felt that it did not provide any new information. Others felt it was having a large impact in encouraging state Medicaid agencies and health plans to cover housing-related services.

BOX 3

CMS Guidance on Coverage of Housing-Related Activities and Services for Individuals with Disabilities

Individual housing transition services

- Conducting a screening and housing assessment and developing an individualized housing support plan
- Assisting with the housing application and the housing search process
- Identifying resources to cover expenses such as security deposit, moving costs, furnishings, adaptive aids
- Ensuring that the living environment is safe and ready for move-in
- Assisting in, arranging for, and supporting the details of the move
- Developing a housing support and crisis plan that includes housing retention services

Individual housing and tenancy sustaining services

- Early identification and intervention for behaviors that may jeopardize housing
- Education and training on the roles, rights, and responsibilities of the tenant and landlord
- Coaching on developing and maintaining key relationships with landlords/property managers
- Assistance in resolving disputes with landlords and/or neighbors
- Advocacy and linkage with community resources to prevent eviction if housing is jeopardized
- Assistance with the housing recertification process
- Coordinating with the tenant to review, update, and modify their housing support and crisis plan
- Continuing training on good tenant practices and lease compliance

State-level housing-related collaborative activities

- Developing formal and informal agreements and working relationships with state and local housing and community development agencies to facilitate access to existing and new housing resources
- Participating and contributing to the planning processes of state and local housing and community development agencies
- Working with housing partners to create and identify opportunities for additional housing options for people wishing to transition to community-based housing

Source: <https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-06-26-2015.pdf>.

Although none of the partnerships we studied has yet incorporated the CMS guidance on housing-related services into state plan or waiver benefit packages, New York State recently submitted an 1115 demonstration waiver amendment to cover these services. Until the amendment is approved, New York's MRT programs generally rely on state funding to cover services in supportive housing.

Several other states have either recently received or are currently negotiating with CMS for approval to have Medicaid pay for housing-related services. For example, California's Medi-Cal 2020 1115 waiver renewal, approved by CMS in December 2015, created a whole-person care pilot program to provide the housing-related services outlined in the CMS informational bulletin for qualifying Medi-Cal beneficiaries.¹⁸ It also provides incentive payments to encourage MCOs to form regional partnerships with county governments, hospitals, and local housing authorities to increase access to housing. These payments could be used to support the creation of memoranda of understanding and data sharing agreements between partners and to develop a process to help eligible Medi-Cal beneficiaries find and maintain housing. Oregon is negotiating its 1115 renewal with CMS and is seeking Medicaid reimbursement for housing-related services.

The HWS initiative has relied primarily on grants and in-kind contributions of staff from member organizations for housing-related services. Even though PMPM payments were discussed during the development of HWS, CareOregon, its health insurance partner, provides in-kind staff rather than PMPM reimbursement for the service package for program participants, in part to dispel any perception that the apartment buildings are assisted living programs. Further, much of the work HWS staff does is connecting tenants to existing health and health-related services that are eligible for Medicaid or Medicare reimbursement.

Houston receives Medicaid funding for a package of clinical and supportive services through its Section 1115 waiver. DSRIP payments under the waiver allow the city's health and human services department to pay FQHCs \$8,000 per person per year for integrated services in supportive housing. The flexible DSRIP funding can be used to pay for services for qualifying people who are not yet enrolled in Medicaid. The waiver, which is being renegotiated with CMS, has been extended with current funding levels through the end of 2017.¹⁹

Challenges associated with limits on federal Medicaid funding to cover housing-related services pale in comparison to the challenge of expanding the availability of affordable housing for Medicaid beneficiaries. Federal rental assistance program funding serves only one in four eligible households. Many applicants spend years on housing authority waiting lists before being offered assistance, and more than 11 million households spend at least half of their income on rent each month.^{20,21} Medicaid

expansion, along with new care coordination models such as Medicaid Health Homes and ACOs, have raised awareness within the health care field of the unmet need for housing. Health care systems have responded in different ways to this shortage of affordable housing and its effect on health care use and costs. One approach is to make direct investments in housing construction or rental subsidies to expand the supply of affordable and supportive housing. Because these costs are not Medicaid-reimbursable, funding must come from the state or other sources. Another option is for state Medicaid agencies, health plans, assisted living providers, or other advocates for independent living for people with disabilities to forge connections with state housing finance agencies, PHAs, or affordable housing property managers to establish preferential access to existing units for targeted populations. A third, more long-term option is to lobby legislatures for greater investment in HUD and other housing agencies' affordable housing programs. These approaches are not mutually exclusive and can be complementary. Some policy experts we interviewed indicated that the health care system should not be expected to solve the affordable housing problem, but it could play a role in making the business case for increased investment in housing. One expert noted, "We've gone way too far in essentially demolishing HUD and trying to find ways that Medicare and Medicaid should fund housing that we eliminated at the HUD level. I think that's a wrong direction to go." Another expert argued that large health insurers, hospital networks, and other key stakeholders should be taking the long view of working within the existing system to advocate for increased HUD funding for affordable housing.

New York State is the most prominent example of a Medicaid agency directly investing state savings into housing development and construction. The state's MRT investment helps fund units that are primarily financed by state housing finance agency bonds in combination with 4 percent LIHTC. Nationally, most supportive housing projects rely on 9 percent tax credits to subsidize the capital costs of new development.²² This is a subtle but crucial point. Although bonds (and their attendant 4 percent credits) and 9 percent credits are all allocated to states on a formula basis, 9 percent credits are the most limited and sought-after resource because they are the most lucrative for developers; they cover 70 percent of the construction costs, compared with 30 percent for the 4 percent credits. New York's use of bonds and 4 percent credits means that its MRT SHPs are likely to increase the overall supply of affordable housing throughout the state without crowding out other potential projects that depend on 9 percent credits.

No other state has made a similar commitment to use its state share of Medicaid savings to pay for housing. A number of factors make New York unique: the savings it has generated from reforming an expensive and underperforming state Medicaid system; a governor with roots in the homelessness and affordable housing communities; and the New York/New York Agreements, a city-state collaboration

that pools resources to pay for supportive housing.²³ However, all states stand to benefit from investments to increase access to community-based housing for high-cost, high-need Medicaid beneficiaries, and more states are using the 1115 demonstration waiver process to exercise this authority. California's Medi-Cal 2020 demonstration waiver creates nonfederal, community-based shared savings pools that can be used to pay for long-term rental assistance.²⁴ Oregon's 1115 renewal application includes plans for a five-year pilot program to fund homelessness prevention, care coordination, and supportive housing services.²⁵ Oregon is requesting federal Medicaid funding to support the planning process and to pay for care management. It estimates that the pilot will reduce total annual Medicaid expenditures by approximately \$500 to \$800 million.

Organizations interested in expanding access to community-based housing, including state Medicaid agencies, health plans, and homeless service providers, can also form partnerships with housing authorities, housing finance agencies, and other housing providers to help targeted populations get preferential access to existing housing resources (e.g., housing choice vouchers). Housing authorities have broad discretion in setting their wait list preference to determine the order in which qualified households are offered assistance, although they must make sure that their preferences do not violate fair housing law by limiting the availability of housing for protected classes including gender, race, and disability status. The Houston Housing Authority used this discretion to amend its wait list preferences for the housing choice voucher program to prioritize participants in the Integrated Care for Chronically Homeless program. Because all PHAs have discretion to set preferences for their affordable housing programs, this is a broadly replicable and scalable way to pair housing assistance with health care services. However, though working with PHAs to amend wait list preferences can be extremely beneficial for targeted populations, it does not increase the overall availability of affordable housing; it only changes who has access to it. Moreover, without further investment in building and preserving affordable housing, voucher recipients will have an increasingly difficult time using their vouchers to find apartments on the private market. This already appears to be happening in some tight rental markets such as the San Francisco Bay Area, where many vouchers go unused because recipients must relinquish their vouchers if they cannot find housing that accepts them within 90 days.²⁶

Similarly, state housing finance agencies have broad discretion in setting the criteria for awarding LIHTCs. State Medicaid directors and public housing agencies are working with housing finance agencies to use tax credits to build new supportive housing for people with disabilities. The majority of state housing finance agencies have either a preference or set-aside to encourage developers to include supportive housing units for people with disabilities as part of their tax credit projects.²⁷

Incentives Can Conflict

MCOs See Benefits of Collaboration but Face Payment Disincentives

State Medicaid programs and, particularly, Medicaid MCOs could play an important role in health and housing integration efforts. The number of individuals enrolled in Medicaid managed care plans increased from roughly 19 million in 2007 to 42.5 million in 2014, and 77 percent of all Medicaid enrollees are in managed care plans.²⁸ Managed care plans receive a fixed Medicaid payment (capitated rate) per member. They have broad discretion in deciding how to use those funds, along with a financial imperative to keep their costs down without sacrificing quality of care. Program and policy experts reported that MCOs increasingly see the benefit of community-based housing as a way to prevent institutional placements and the spiral of negative outcomes and high health care costs associated with homelessness. Many of the larger health plans have hired housing specialists to help them understand how they can work with housing providers to connect members to housing. However, MCOs face a number of obstacles in successfully integrating housing into their plans.

One obstacle cited by experts is the learning curve associated with housing. One expert said, “You can’t call up a developer the same way you can call up a podiatrist.” It takes time to understand the different housing programs available and their eligibility requirements and preferences. Given the shortage of housing and rental assistance, health plans also can face lengthy delays before members are able to find affordable housing. It can take a year or more after a person is referred to a housing program before they are offered assistance.

Even MCOs that recognize the importance of housing and are interested in committing resources may face financial disincentives. Specifically, in the methodology for setting their rates, MCOs can only include spending on services approved for federal Medicaid reimbursement. Therefore, if an MCO decides to use flexible funding to pay for housing-related expenses such as rental application fees to help keep its members in stable housing and out of hospitals or nursing homes, the spending may be categorized in rate setting as administrative costs rather than medical spending. The MCO will appear to be investing more in itself and less in providing medical care to its members. If an MCO achieves savings in traditional medical expenses—for example, by reducing unnecessary use of ED or inpatient services—but cannot count the health-related spending that contributed to savings as medical spending, its overall payment rate will fall over time. In July 2016, CMS released new managed care rules that address incentive payments and quality withholds, but none of the changes and new rules addresses these structural disincentives.²⁹

Despite these obstacles, the experts in our study indicated that some MCOs are interested in covering housing-related services for eligible members. There appears to be widespread agreement that these services are more effectively covered in a bundled payment structure than reimbursed as discrete services. However, MCOs have limited data to guide decisions about where to set payment levels, how and when to taper down payments over time, or what outcomes to expect in terms of improved functioning or reduced health care costs associated with more stable housing. Nonetheless, covering housing-related services could be a role for MCOs if the technical challenges around benefit design and rate setting can be addressed.

Show Us the Data

Acquiring and Using Data to Support Collaboration Can Be Challenging

The importance of data sharing emerged in almost every conversation with program and policy experts. At the planning level, health care providers and payers generally do not have information about the housing status of their patients or members. ICD-10, the most current version of the International Statistical Classification of Diseases and Related Health Problems, includes a homelessness diagnosis code, billable for inpatient hospital admissions.³⁰ However, completing the code may not be tied to payment in all cases, so hospitals do not necessarily have an incentive to capture this information. Recently, the National Health Care for the Homeless Council urged CMS to encourage hospitals to use the code for people experiencing homelessness who are seen in emergency rooms or admitted to an inpatient stay as part of the proposed discharge planning rules under development.³¹ State Medicaid agencies have an opportunity to encourage integration by tying the homelessness diagnostic code to payment. The US Department of Veterans Affairs' (VA) health system offers a precedent: it instituted a universal Homelessness Screening Clinical Reminder. All veterans receiving VA outpatient health services are asked a two-question screener to assess whether they are experiencing homelessness or at risk of homelessness. Patients who meet the criteria are then asked two follow-up questions to gauge their interest in a referral to VA homelessness or homelessness prevention programs.³²

The federal government will reimburse 90 percent of the costs for design, development, and installation for states that modify their Medicaid Management Information System (MMIS) to support real-time data identifying high-cost, high-need Medicaid beneficiaries experiencing homelessness. MMIS funding can support data infrastructure by developing data feeds that are delivered to providers and programs in real-time and MMIS analytic tools that enable providers to better understand high-need, high-cost Medicaid beneficiaries who are experiencing homelessness.

Absent a top-down solution, local housing and health care providers are coming together to share data. In Houston, FQHCs purchased electronic health records from Harris County to track ED visits for individuals enrolled in the Integrated Care for the Chronically Homeless program. In Los Angeles, county safety net hospitals have created a homelessness flag in their data system to identify patients who may qualify for the Housing for Health program. In Fort Worth, Texas, the Anthem health plan is collaborating with John Peter Smith Hospital to identify people experiencing homelessness and frequent hospital users and partnering with the Salvation Army to place them in supportive housing.

Housing providers also must be able to share information with health plans about how many members of a particular plan reside in their buildings. Knowing what health insurance plans tenants belong to is critical for approaching the appropriate health care payers and making the business case for investing in on-site services within a housing development.

During the implementation phase as well as ongoing program operation, data sharing can be critical for both housing and health care providers. Health plans want detailed information on members' nutritional status, mental health, cognition, and ability to perform daily activities. The property manager may have information about tenants' health and functioning that would be useful to their health care provider—for example, whether the person is suicidal or off their medications or in danger of slipping and falling on an icy patch in front of their apartment. However, the typical housing provider does not usually have a relationship with local health plans that would allow relevant information to be shared.

Besides the lack of infrastructure to collect and exchange information between different partners, housing providers can also be frustrated by health care organizations' inability to share data with them because of regulations governing the disclosure of sensitive health information (e.g., the Health Insurance Portability and Affordability Act [HIPAA] and requirements to obtain the individual's consent to share with others). Some states may have even stricter privacy regulations than federal law, and sometimes providers are unsure what information can be shared and err on the side of caution. In interviews, program staff noted instances of MCOs not being able to respond to housing providers' requests for members' diagnostic information. In one case, a housing provider was trying to locate a tenant, but the health plan would not disclose that the tenant was hospitalized. This type of miscommunication can lead to housing instability. For example, a person discharged from a hospital may lose his or her bed in a shelter if the shelter provider is unable to reach them.

None of the programs highlighted in this brief had integrated data systems between housing and health providers. In Houston, for example, the FQHC and homeless services provider integrated their records, but no data were shared with the housing provider. Portland has a similar arrangement in

which health care providers share data with each other, but the housing provider uses its own system that is, according to one respondent, “a hundred percent walled off between the housing and health care side.” The policy experts we interviewed suggested that it is possible to share client data between housing and health care providers under HIPAA by recognizing a housing provider as a member of the health care team, but sharing is more likely to be successful if data are flowing from the housing provider to the health care provider. Given these structural barriers, communication and good working relationships become even more important in housing and health collaboration projects. Even when data sharing issues have not been resolved, providers participating in Integrated Care for the Chronically Homeless and HWS work together in a highly collaborative way.

Finally, data sharing is critical for understanding the outcomes and cost implications of housing and health care partnerships. Each of the partnerships highlighted in this brief collects data for evaluation purposes, and the data have been critical for making the case to sustain and expand the programs.

What to Do When Funding Ends?

Sustainability Requires Commitment and Creativity

When policymakers and providers think about funding collaborations, two questions arise: (1) How do we obtain funds for planning stages and upfront costs of implementing new programs? (2) How do we secure funding to sustain programs long-term? Although interest in integrating housing and health is gaining momentum nationally, efforts in this area are still relatively new, with no single path forward or dedicated funding streams established. Often, health and housing initiatives begin as pilots and may be supported through various provisional funding sources such as grants and philanthropy. For example, the development and launch of Portland’s HWS pilot has been funded through the LLC partner equity and in-kind contributions, a CMS SIM grant, and financial contributions from a number of foundations and institutions. Sometimes, health and housing programs can benefit from a relatively stable funding stream, such as New York’s investment of the state portion of its Medicaid savings into supportive housing and services and DSRIP funding of New York and Houston’s programs. But even these funds can come to an end. The amount of DSRIP funding available to Houston under the Texas Section 1115 waiver was negotiated in 2011 based on the assumption that Texas and all other states would be required to expand Medicaid eligibility to 133 percent of FPL. Texas has so far chosen not to expand eligibility, and CMS has warned that, going forward, it will not approve uncompensated care funding at the current level.³³

Whether a program is funded through a grant or supported by state funds, long-term sustainability is a concern. Program and policy experts agree that the promise of costs reduced or money saved is often the primary motivation for a health care system to collaborate with housing in the first place, as well as the main driver for maintaining and scaling successful programs. Building a comprehensive evaluation component into new programs can be critical for their long-term sustainability prospects. HWS is using SIM funds to contract with Portland State University and Providence Center for Outcomes Research and Education for an evaluation of program impacts on service use and costs; health outcomes; housing stability; and improved access to health, mental health services, and culturally specific services. The evaluation findings, which are expected to show reduced health care costs and progress toward the other objectives, will be used to make the case for ongoing commitment to the project from the current LLC partners and to pursue support from health care stakeholders, such as hospital systems and health plans that stand to benefit from improved health and use outcomes of their patients and members.

Houston's Integrated Care for the Chronically Homeless has used data showing increased physical and mental health functioning, decreased depression, and reductions in ED usage by participants to access additional DSRIP funds and grow its program.³⁴ The program's initial success has generated discussions with local MCOs about supporting the integrated care model. Only about 30 percent of program participants were enrolled in Medicaid at initial intake, but an analysis of historical data showed that many people experiencing chronic homelessness are eligible for Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) benefits and Medicaid. The process of obtaining SSI or SSDI can take several years, so there will likely be a long delay between program entrance and Medicaid payment for most participants in the Integrated Care for the Chronically Homeless program. As a result, the program will require other payment sources for several years until the mix of Medicaid patients is sufficient to sustain the program. Moreover, Medicaid beneficiaries who experience chronic homelessness are often difficult for MCOs to locate and care for, so MCOs benefit from supporting the integrated care model that brings housing to these individuals and helps them stabilize. Despite Texas's decision not to expand Medicaid eligibility, providers still have incentives to reduce rates of unnecessary ED visits and inpatient readmissions. The state Medicaid office took notice of Houston's integrated care model and is considering piloting the program throughout the state. If these plans are realized, participation from Medicaid and MCOs will not only sustain the model in Houston but also expand it throughout Texas.

Beyond sustaining ongoing projects, there is considerable interest in testing new models and scaling up and replicating successful health and housing collaborations. As mentioned above, Oregon

has included in its draft 1115 Medicaid waiver renewal application a proposal for a pilot program to test new health and housing integration models. Through its participation in the Medicaid Innovation Accelerator Program (IAP),³⁵ Oregon is hoping to better coordinate efforts between state and local health and housing agencies and learn how best to leverage Medicaid funds to pay for allowable tenancy supports.

In New York, MRT supportive housing projects must agree to share Medicaid claims data on tenants with the state's Medicaid data warehouse. An independent evaluator then analyzes changes in Medicaid spending before and after placement into supportive housing. This analysis is used to demonstrate the cost savings of the program to sustain funding. In addition to analyzing Medicaid data, the state is trying to get access to Medicare data to show that both Medicaid and Medicare programs can realize savings by placing high-need, high-cost populations into supportive housing. New York is hoping to expand its supportive housing initiatives through its Section 1115 waiver negotiations. The state plans to take full advantage of the recently issued CMS guidance on housing supports and keep reinvesting the savings realized from reductions in inappropriate use of costly medical services to create more supportive housing. According to state officials, New York is also planning to once again request permission to use the federal portion of Medicaid savings for capital investments and rental assistance.

Even successful health and housing integration projects take time to show cost savings. Houston's initiative saw improvements in health status and reduction in inappropriate ED use, but the overall health care use of the participants actually increased in the first year, and savings were not realized until the second year of the program. Houston's effort targets a particularly vulnerable population, prioritizing the most acutely ill subset of people experiencing chronic homelessness, whose physical and mental needs may have been neglected for a long time. For this population, health care use and costs may rise initially, and it may take time for the program to have the desired impact on costs. For some program participants with high acute care needs (e.g., people with terminal cancer), health care use and costs may not decrease substantially. But as the program expands to include people with less acute conditions, overall health care costs are expected to decline. On balance, the policy and program experts we interviewed believe that investments in stable housing, preventive health care, and wraparound supports will translate into health care savings.

Conclusion

In this brief, we have shown that challenges to health and housing integration are significant but not insurmountable. States and localities have many opportunities. Providing Medicaid-reimbursable supports and housing-related services to help people maintain housing stability seem to be low-hanging fruit available to any Medicaid program. Despite the shortage of affordable housing nationally, state housing finance agencies and local housing authorities have opportunities to set priorities for LIHTCs and vouchers to target individuals with the most need and greatest cost to the public health system. State and local governments can foster health system integration with housing and social services by creating incentives for health plans to address social determinants of health, developing linkages between state and local agencies and providers on the ground, and encouraging integration through outcome measures (e.g., proportion of beneficiaries with stable housing) and alternative payment methodologies (e.g., providers share in savings from improved outcomes). The federal government can foster cross-system collaborations by continuing to provide guidance and resources to states and localities on the tools and authorities available. Concrete policy changes that may further support health and housing collaboration include revisions to or clarifications of the Medicaid managed care rate setting methodology and rules guiding the protection and exchange of patient data.

When asked to provide advice on implementing health and housing collaborations, the experts we interviewed frequently said, “Just do it!” But many to states, localities, and organizations interested in collaboration struggle with how and where to start. They would benefit from technical assistance, ranging from basic how-to’s to sophisticated and tailored help on advanced collaborations. They can draw on a variety of resources and toolkits, as well as hands-on assistance from national organizations (e.g., CSH) and local efforts to encourage health and housing integration (e.g., the Bronx Health and Housing Consortium). CMS offers assistance and resources to state Medicaid agencies through the Medicaid IAP design to support Medicaid innovation and accelerate new delivery and payment reforms. One of IAP’s programs focuses specifically on Medicaid housing-related services and partnerships.³⁶

We have developed technical assistance materials based on our [examination of existing collaborations](#) and discussions with health and housing policy experts. With so much interest and activity in the area of housing and health care collaboration, the range of toolkits, policy briefs, webinars, and other resources continues to grow. Our aim is to focus on basic information helpful to organizations or individuals interested in taking the first steps in developing a collaboration, from [how to identify and engage the right partners to what issues to consider during planning and implementation](#).

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About the Authors

Brenda C. Spillman is a senior fellow and health economist in the Urban Institute's Health Policy Center. She has more than 25 years of experience designing and conducting health and health care–related research projects. She has expertise in survey design and extensive experience in using a broad range of complex national surveys, Medicare and Medicaid claims, and assessment data. She is coinvestigator and leadership team member for the National Health and Aging Trends Study, a longitudinal survey of the Medicare elderly.

Josh Leopold is a senior research associate in the Metropolitan Housing and Communities Policy Center at the Urban Institute, where his work focuses on homelessness and affordable housing policy. Before joining Urban, Leopold was a management and program analyst at the US Interagency Council on Homelessness (USICH). At USICH, he helped implement the Obama administration's plan for ending chronic homelessness and homelessness among veterans by 2015; he also helped develop a national research agenda related to homelessness.

Eva H. Allen is a research associate in the Health Policy Center at the Urban Institute, where she works primarily on evaluation studies of various federal and state health care reform initiatives. Before her current position, Allen worked as a project associate in the center. Allen holds a BA in sociology and an MPP from George Mason University.

Pamela Blumenthal is a former senior research associate in the Urban Institute's Policy Advisory Group.

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