

Affordable Housing's Place in Health Care

Opportunities Created by the Affordable Care Act and Medicaid Reform

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The Patient Protection and Affordable Care Act (ACA) has changed the landscape of health care policy in the United States and has opened up opportunities for the housing and health communities to work together to improve outcomes for individuals and families. Passed in 2010, the ACA is propelling a transition away from traditional health care payment systems and models of delivering health care towards a greater focus on care coordination and prevention in order to improve overall health outcomes while containing rapidly rising health care costs. The legislation attempts to change health care systems by

incentivizing—and requiring in some cases—attention to social determinants of health and by promoting innovative models for delivering health care services.

The ACA also enacted changes to the Medicaid program, a government-funded health insurance program for low-income individuals, that present opportunities to better meet the health care needs of low-income and vulnerable individuals who are served by affordable housing providers. Because housing is a key social determinant of health, stable and affordable housing is

an important part of a comprehensive strategy for achieving better health outcomes among low-income individuals.¹ Furthermore, using housing as a platform for promoting health can result in lower costs than traditional health care strategies.

This report examines several ways in which health care changes created by the ACA, and other health care reform initiatives, create the potential for affordable housing providers to collaborate with health care providers, insurers, and other institutions to support the wellbeing of low-income individuals and families.



Housing is a Social Determinant of Health

Housing is an important social determinant of health, meaning that the quality, location, and cost of housing impact residents' health.² Poor quality housing or housing located in neighborhoods with harmful environmental exposures can contribute to poor health in both children and adults.³ Unaffordable housing—measured as housing costs that exceed 30 percent of households' income—requires households to cut back on other necessities, which often means going without nutritious food or health care services.⁴ The stress of homelessness or unstable housing situations negatively impacts mental health for people of all ages.⁵

Access to safe, adequate, and affordable housing in neighborhoods of opportunity and investment in high quality affordable housing can support positive health outcomes and reduce health care spending. For example, recent research has shown that the redevelopment of low-quality housing and investments in weatherization and energy efficiency upgrades can result in myriad positive health outcomes, including reductions in asthma symptoms and emergency room visits, while at the same time reducing health care spending by both families and the public sector.⁶

Research has demonstrated that social determinants of health,⁷ including housing and neighborhoods, are responsible for up to 40 percent of individual health outcomes.⁸ A majority of physicians believe that it is just as important to address the social needs of patients as well as their health needs. Physicians traditionally have not discussed or addressed social needs as part of their treatment because they typically do not receive payment for those conversations and also because few receive

training or education on how to respond to social needs.⁹ The health care system changes enacted by the ACA are meant to change this tendency. Through expanded flexibility and financial incentives, the ACA encourages health care providers to better coordinate patient care, focus on prevention, and consider needs that fall outside the traditional purview of medical care yet still impact health. Affordable housing serves some of the most vulnerable individuals and families who often have the most serious and costly health needs and can be an important platform for addressing social determinants of health. The expansion of the Medicaid program's new populations, in particular, offers opportunities for the affordable housing community to partner with the public health community to meet the needs of lower-income individuals and families.

Medicaid Basics

The Medicaid program is a partnership between the federal government and states to provide health care coverage to low-income individuals. Each state submits a state plan, which outlines services covered by its Medicaid program, for approval by the Centers for Medicare and Medicaid Services (CMS), the federal agency that regulates the Medicare and Medicaid programs. The state plan functions as a contract that ensures each state Medicaid program complies with federal regulations regarding services eligible for Medicaid reimbursement and individuals eligible for Medicaid coverage. One of the important stipulations of the Medicaid program is that services must be available statewide to eligible Medicaid beneficiaries (with a few exceptions). Each state receives a federal match for a portion of its Medicaid expenditures called the Federal Medical Assistance Percentage (FMAP). The level of the FMAP varies by state, ranging from a 50 percent match to a 74 percent match of state Medicaid expenditures. The FMAP calculation for each state is based on income so that states with lower average personal income receive a higher FMAP.¹⁰

Three kinds of systems are used to deliver health care to Medicaid beneficiaries:

- 1. Fee-for-Service:** Health care providers are paid by the state Medicaid program for each service they provide to a Medicaid beneficiary (such as a doctor visit or medical procedure).
- 2. Managed Care:** A managed care organization (MCO) offers health care services directly or contracts with health care providers. MCOs receive a capitated payment rate from the state Medicaid program, a predetermined per-member payment rate regardless of services utilized by MCO members.
- 3. Integrated Care:** Organizations that offer a wide array of health and social services through one consolidated system and typically receive a capitated payment rate from the state Medicaid program.



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Approximately 70 percent of Medicaid beneficiaries are currently enrolled in MCOs.¹¹ Typically, MCOs exclude disabled and elderly Medicaid beneficiaries due to the high cost of caring for these populations, though many states are beginning to mandate the inclusion of these populations in MCO contracts in order to better contain Medicaid expenditures. MCO contracts also often exclude some kinds of acute or specialized care, such as behavioral health care or substance abuse treatment, so those services are typically administered through a fee for service system.¹² Integrated care systems, such as accountable care organizations and health homes, which will be discussed later, are a new approach to effectively caring for populations with complex and high-cost health needs that many state Medicaid programs are beginning to explore.

Medicaid Waivers and Health Care Reform

Before the ACA legislation was passed, a Medicaid waiver was the main avenue for states to try new models for delivering health care to Medicaid beneficiaries. Now that the ACA has been passed, Medicaid waivers remain important tools for states to test new ways to structure their health care systems. States apply to CMS for waivers to request permission to alter some Medicaid rules in order to try out new health care payment or service delivery models that require more flexibility than is allowed in state plans. States frequently use two waivers to experiment with new ways of paying for health care or delivering health care to Medicaid beneficiaries:¹³

► Section 1115 Research & Demonstration Projects

States apply for a Section 1115 demonstration waiver to carry out demonstration projects that require greater flexibility in eligibility rules and services offered than what the federal Medicaid rules allow. For example, a Section 1115 demonstration waiver may allow states to offer Medicaid services to individuals who may not otherwise be eligible for Medicaid or the Children's Health Insurance Program (CHIP)—a health care program similar to Medicaid for low-income children between the ages of 6 and 18—based on income or medical need; offer services not typically reimbursable by Medicaid; or use a new delivery system or manner in which people can access health care services, with the goal of reducing Medicaid costs and/or improving the quality of medical care.¹⁴ The demonstrations authorized by Section 1115 demonstration waivers have a five-year timeline and may be approved by CMS for a three-year extension.¹⁵ One of the key requirements of a Section 1115 demonstration waiver is that the demonstration be budget neutral, meaning that the project will not result in higher federal Medicaid spending than would otherwise result from standard Medicaid program regulations.¹⁶ It also waives Medicaid's requirement that comparable services be offered statewide

Health Care Terms Housing Providers Should Know

Activities of Daily Living: Essential daily tasks such as bathing, eating, and dressing.

Capitation: A health care payment approach that encourages health care organizations to keep costs low in order not to exceed the average total cost of care that determines the capitation rate, or total payment for the patient population regardless of services actually used.

Dual Eligible: A term for individuals who are eligible for Medicaid and Medicare enrollment.

Fee-for-Service: A health care payment approach that reimburses health care providers on a per-service basis.

Long-Term Care: A broad array of health and supportive services for individuals with chronic conditions who need services over a long period of time.

and beneficiaries' right to seek services from any health care provider willing to participate in the Medicaid program. The ACA authorized new Medicaid state plan options (see below) that give states flexibility in administering their Medicaid programs with some new payment and health care delivery systems without having to seek an 1115 demonstration waiver.

► Section 1915(c) Home and Community-Based Services (HCBS)

Before 2005, CMS only allowed state Medicaid programs to reimburse comprehensive long-term supports and services administered in institutional settings such as nursing homes and two limited, home-based options for long-term supports and services. In the 1970s, CMS made limited medical home health care a mandatory state Medicaid service for individuals eligible for nursing home admission and offered states the option of adopting medically oriented personal care services as a benefit under their state plan.¹⁷ Prior to 2005, in order to offer the variety of long-term services and supports individuals typically need to avoid nursing home admission, states had to request a 1915(c) HCBS waiver from CMS. The 1915(c) HCBS waiver allows states to offer medical and supportive services (such as case management and expansive personal care assistance) to Medicaid enrollees, who need institutional-level care, in their homes and communities.¹⁸ The 1915(c)

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waiver requires that the HCBS programs be budget neutral. The waiver allows states to limit geographies where services are available, as well as make the programs available only to a targeted population with specific health needs.¹⁹ States can also request in their 1915(c) waiver the authority to offer HCBS to individuals who may not be eligible for Medicaid services due to their income.²⁰

In 2005, CMS authorized states to offer limited HCBS options as part of their state plan in a 1915(i) state plan amendment; however, it did not allow states to target specific populations, such as people with a specific health condition or serve individuals with incomes above 150 percent of the Federal Poverty Level (FPL), so few states chose to adopt the amendment.²¹ The ACA made the 1915(i) state plan HCBS option more attractive and feasible for states by allowing them to target HCBS programs to particular health needs and conditions, covering more kinds of HCBS services, and offering HCBS services to individuals with incomes above 150 percent of the FPL in specific circumstances.²²

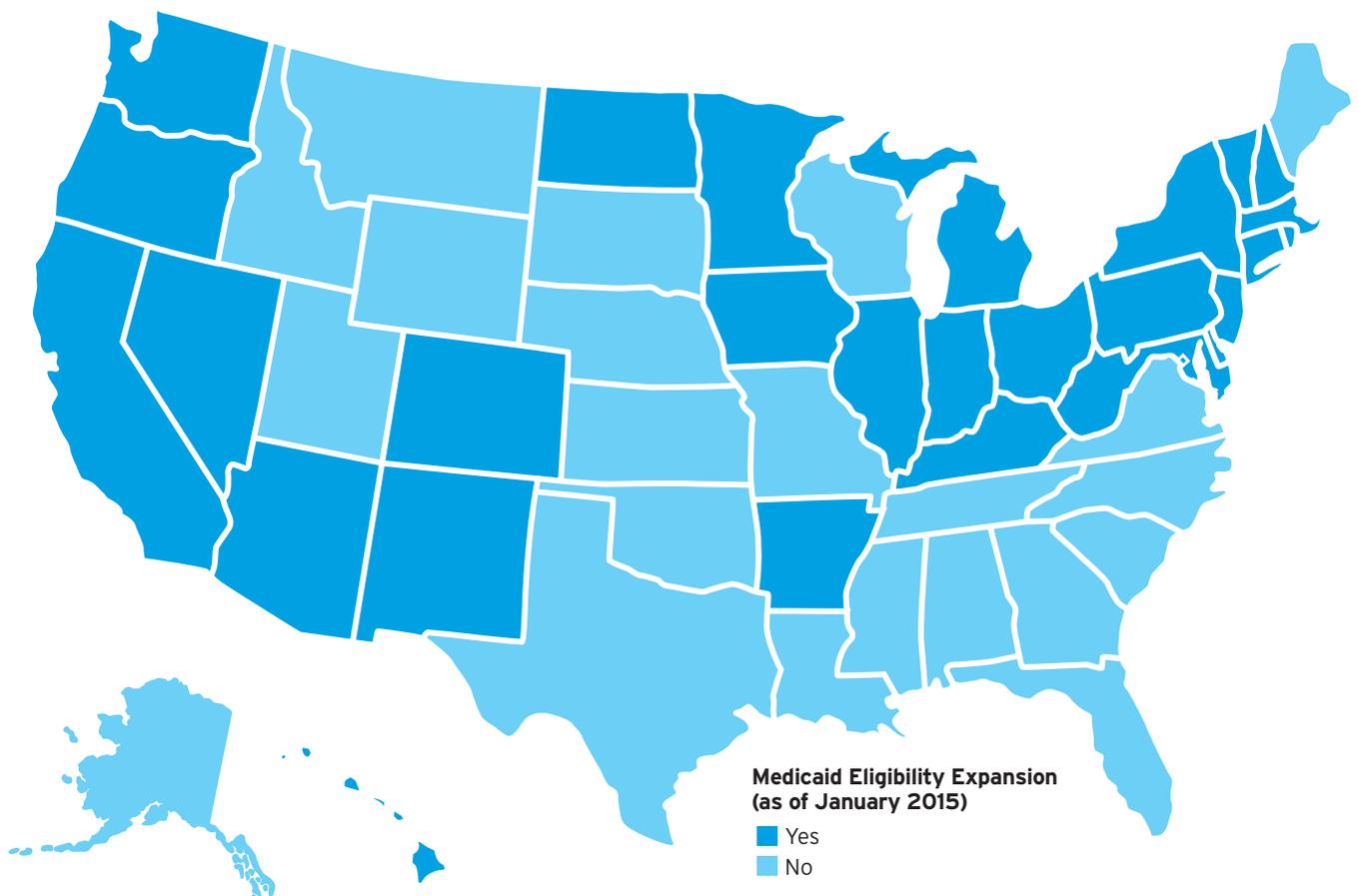
Medicaid Eligibility Expansion

One of the most well-known changes to the Medicaid system by the ACA is the expansion of Medicaid eligibility requirements, opening up Medicaid to many people who were previously ineligible (see Figure 1). Prior to the ACA, the federal government required states to offer Medicaid to these specific populations:

- ▶ Pregnant women and children younger than six years old with household incomes at or below 138 percent of the FPL.
- ▶ Children, aged 6 through 18 years, in households with incomes at or below 100 percent of the FPL (through CHIP).
- ▶ Disabled adults or adults 65 and older who were eligible for Supplemental Social Security Income.²³

Initially, the ACA legislation *required* all states to expand Medicaid eligibility to cover all those under the age of 65

FIGURE 1. States with Expanded Medicaid Eligibility



NOTE: Arkansas, Indiana, Iowa, Michigan, New Hampshire, and Pennsylvania expanded Medicaid eligibility, adopting more narrow criteria than the ACA, using Section 1115 waivers.

Source: Kaiser Family Foundation. *Status of State Action on the Medicaid Expansion Decision*. Menlo Park, CA: March 2015. Retrieved from <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>.

with household incomes at or below 138 percent of the FPL. States were also required to expand CHIP eligibility to those in households with incomes up to 138 percent of the FPL.²⁴ In exchange, the federal government would match 100 percent of states' Medicaid spending for these newly eligible beneficiaries from 2014 to 2016. The FMAP would then decrease incrementally to 90 percent by 2020.²⁵

A 2012 Supreme Court decision, however, made state Medicaid expansion voluntary.²⁶ While expansion of Medicaid eligibility has been controversial, many states have opted to expand their Medicaid eligibility in order to access the federal match. As of January 2015, 24 states have adopted the ACA's new eligibility guidelines, as shown in Figure 1.²⁷ Some states have been unwilling or unable to take up the ACA's eligibility expansion due to the political climate in their states, but have used waivers to pursue more limited eligibility expansion. As of March 2015, six states have requested Section 1115 demonstration waivers to expand their Medicaid eligibility guidelines, along with some non-ACA measures such as charging premiums for certain Medicaid beneficiaries or incentivizing healthy behavior. Under these waivers, these states will be able to receive the enhanced FMAP for new enrollees.²⁸

Overall, the ACA and recent rule making by CMS offer states greater flexibility and create financial incentives to contain Medicaid expenditures and deliver high quality health care through innovative health care payment and delivery approaches. Health care organizations like hospitals, health insurance organizations, and health care providers are encouraged, or in some cases required, to expand the traditional approach of health care to focus more on prevention, care coordination, and attention to social determinants of health. These developments at the state and health care provider levels create opportunities for health care providers to collaborate with affordable housing providers and health and housing organizations to work together to address the health needs of low-income individuals. The following programs and changes authorized by the ACA and other health reform initiatives offer the greatest promise for cooperation between affordable housing providers, organizations, and the health care sector.

Accountable Care Organizations

Accountable care organizations (ACOs) constitute a relatively new payment model for delivering health care that coordinates all of the different health care services a patient receives, breaking down traditional health care silos.²⁹ An ACO is a network of health care providers and organizations, like hospitals, managed health care plans, and doctors, that collaboratively coordinate the health care of patients. An ACO also focuses explicitly on containing the overall cost of the continuum of care.³⁰ Medicaid requires that ACOs meet quality of care standards and issue ACOs a share of any savings achieved when they deliver health care at lower costs than budgeted for per-member payments. This payment creates

a strong incentive for ACOs to invest in preventative care for their patients.³¹ The 10 states with Medicaid ACOs³² have set up their systems in a variety of ways, including offering patients flexible one-time grants for health care expenses, per-member payments that are adjusted to account for the cost risks of the patient population, and global payment systems that blend Medicaid and non-Medicaid funds to serve as a common budget for medical and non-medical services offered by the ACO.³³

The Role for Affordable Housing Providers

The holistic approach that ACOs take to providing health care, and their financial obligations to deliver quality care at low costs, create strong incentives for ACOs to partner with organizations that can effectively address the social determinants of patient health. If affordable housing providers can demonstrate their ability to support the health of patients, ACOs may provide funding to housing providers to deliver non-medical services such as health education and hospital discharge planning. Funding from ACOs can serve as a sustainable source of funding for services that many affordable housing providers already offer to support the health and wellbeing of their residents and ensure that they can be stable long-term tenants. Affordable housing providers can also help ACOs conduct outreach to inform low-income households about their eligibility to enroll in ACOs, since outreach to Medicaid enrollees is often a major challenge for ACOs.³⁴

Many states are encouraging ACOs to include social supports as part of their care coordination strategies. For example, Minnesota requires that Medicaid ACOs form partnerships with social service agencies and other community-based organizations to coordinate the medical care and social services needed by patients.³⁵ Hennepin Health is an ACO in Hennepin County, Minnesota, that consists of a partnership of four county agencies—the Hennepin County Human Services and Public Health Department, the Hennepin County Medical Center, the Metropolitan Health Plan, and the NorthPoint Health & Wellness Center. Approximately 30 percent of Hennepin Health members face housing instability or are homeless, so Hennepin Health employs social workers and housing counselors to help members address their housing needs as a part of addressing health risk factors.³⁶ Affordable housing providers and tenant assistance groups could similarly partner with other ACOs to offer assistance to members who need help finding affordable housing. Hennepin Health uses a Medicaid capitated structure, which means the ACO receives a predetermined Medicaid payment based on the number of members. If the ACO spending exceeds the Medicaid payments, it will not receive additional reimbursement for the services it covers. If Hennepin Health does not use all of the Medicaid payment, it will be awarded a portion of the savings by Medicaid.



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Medicaid Health Homes

The ACA created a new Medicaid state plan option called health homes, a payment and health care delivery model similar to ACOs, consisting of a single health care provider, a team of health care providers, or a managed care organization, that coordinates and integrates an individual's health care and referrals to social services. Medicaid health homes are designed to specifically serve individuals with chronic conditions, such as heart disease or asthma. Health homes serve children and adults with at least two chronic conditions, one chronic condition and at risk of developing a second, or a serious and persistent mental illness. The goal of health homes is to improve the quality of care and health outcomes for the chronically ill and reduce Medicaid spending on this often costly population through better care coordination and a focus on the "whole person."³⁷

To encourage states to adopt health homes into their state plans, CMS increased the FMAP for health home services to 90 percent, above the state's standard FMAP for Medicaid spending, for the first two years of the program.³⁸ Unlike other Medicaid state plan options, health homes are not required to be offered statewide and can target specific geographies. States also have the option to tailor their health homes to target individuals with specific chronic conditions or individuals who meet a specified severity of their condition.³⁹ Frequently, federally qualified health centers, or centers that cater to underserved populations in exchange for higher Medicaid reimbursements, have chosen to become health

homes in order to extend and expand services they already deliver.⁴⁰ As of August 2014, 15 states had created at least one health home program, and each state takes a different approach in targeting specific populations and structuring the payment system and health care delivery system.⁴¹

The Role for Affordable Housing Providers

There is often an overlap between the chronically ill patients served by health homes and the low-income residents served by affordable housing providers. While funding for health homes cannot be used to pay for housing for Medicaid beneficiaries, affordable housing providers should be considered by health homes as a resource for patients and a partner in ensuring patients' wellbeing. By working with health homes, affordable housing providers can help residents resolve health and social issues that might put their housing at risk and result in eviction. Health homes are required to make referrals to social services and supports for patients, as well as provide health promotion activities. This creates openings for affordable housing providers to partner with health homes to offer some of those services.⁴² Affordable housing providers can also aid health homes by educating residents, many of whom may be eligible for health homes, about health care options. Health homes have found it difficult to identify eligible individuals, contact them, and then enroll them.⁴³ Affordable housing providers could be effective outreach partners given their existing relationships with many eligible individuals.

In Connecticut, the Connecticut AIDS Resource Coalition and the Partnership for Strong Communities' Reaching Home Campaign are collaborating to address the housing needs of health home members in a pilot program that identifies and enrolls homeless or at-risk individuals in a Connecticut health home.⁴⁴ This program, called the Connecticut Integrated Healthcare & Housing Neighborhoods (CIHNN), integrates supportive housing with state-funded rental vouchers and health home health care services funded through Medicaid, to improve the health outcomes of those individuals.⁴⁵ CIHNN is served by a partnership of supportive housing providers, health home health care providers, and social service agencies.⁴⁶ The pilot program is undergoing an evaluation to determine its effectiveness in improving physical and mental health outcomes and reducing homelessness, hospital and emergency services use, and admission to shelters and jails.⁴⁷ Evidence of the program's effectiveness may help to pave the way for more partnerships of supportive housing providers and the health homes program to serve vulnerable populations.

The Hospital Community Benefit Requirement and Community Health Needs Assessment

In order to maintain their tax exempt status, nonprofit hospitals must provide a "community benefit," roughly equivalent to the amount of their tax exemption.⁴⁸ In the past, nonprofit or community hospitals would typically count their spending on health care services for underinsured and uninsured patients to satisfy their community benefit requirement.⁴⁹ The ACA now also requires that nonprofit hospitals complete a community health needs assessment (CHNA) every three years. The objective of the CHNA is to assess the most prevalent health needs and barriers to accessing health care and maintaining good health in the community. The institution then must establish strategies for meeting the needs identified in the CHNA. The new process is designed to promote greater involvement of hospitals in local neighborhoods and provide greater transparency and accountability to their communities.⁵⁰ The community needs assessments must be made public and include community stakeholders in discussions of health needs in the community and the formulation of plans to address these needs.⁵¹

The Role for Affordable Housing Providers

CHNAs include data on community health needs that affordable housing providers can use to highlight the intersection of health and housing and advocate for investment in affordable housing. In some cases, this advocacy may lead to direct investment in housing by community hospitals. Since the 1990s, to meet its community benefit obligation, the St. Joseph Health System has invested in the construction of affordable housing in Orange County, California because it recognized the major impact the lack of affordable housing had on the health of its community.⁵² The St. Joseph Health System is also a founding member of the Kennedy Commission, an organization devoted to advocating for affordable housing in Orange County, lending an important voice to efforts to expand affordable housing in its community.⁵³

In addition to using data from the CHNAs to address the lack of affordable housing as a social determinant of health, community hospitals may discover other important health issues that can be addressed through housing investments. For example, high rates of respiratory ailments among children and adults may be caused or exacerbated by poor air quality in their homes as a result of environmental toxins released by mold, excessive dust, and pest infestations.⁵⁴ Community hospitals can use data on incidence of respiratory illness to invest in programs offering education and remediation assistance to address health risks in housing and rehabilitation of existing affordable housing. Affordable housing providers can educate community hospitals on the need for investments of these kinds in their communities and work with them to complete the work identified in CHNAs.

In addition to the new Medicaid options discussed above that serve people of all ages and health needs, some parts of the ACA and health care reform initiatives have the potential to have a greater impact on specific populations such as families with children, older adults, and the homeless. While the programs and initiatives below do not exclusively target any of these populations, some housing-related elements of health care reform address the needs of these populations particularly well.



Connecticut Integrated Healthcare & Housing Neighborhoods (CIHNN), integrates supportive housing with state-funded rental vouchers and health home health care services funded through Medicaid.

Photo courtesy of CSH, www.csh.org

Families with Children

The ACA and expanded Medicaid have increased health care coverage for some low-income families and improved or expanded the kind of health care they can access. In addition to the ways in which ACOs, health homes, and CHNAs will lead to more comprehensive health care for low-income families, there is also a recent Medicaid rule change that has the potential to support further initiatives that address the impact of housing quality on the health of children. Research has established that low-income children living in poorly maintained housing are at risk of lead exposure or environmental toxins that create poor air quality conditions that can cause and exacerbate asthma and other respiratory illnesses.⁵⁵ As a result, the opportunities for housing and health providers to work together can have an important impact on families with children.

Change to Medicaid Rule on Types of Providers Eligible for Reimbursement

In July 2013, CMS updated its rule on service providers eligible for Medicaid reimbursement to be more expansive. Prior to the rule change, only doctors or licensed medical practitioners were eligible to receive Medicaid reimbursement for preventative services.⁵⁶ Since the 2013 change, non-medical and non-licensed practitioners can offer preventative services and receive Medicaid reimbursement as long as the services have been recommended by a doctor or licensed practitioner.⁵⁷ States have the authority to determine service provider qualifications, per CMS approval, needed to be eligible for reimbursement, as well as which services are eligible for reimbursement as long as they comply with the state plan.⁵⁸ Currently the federal government still restricts preventative services to those that directly diagnose, treat, or prevent illness or injury and excludes



Despite the constraint on using Medicaid funds for actual environmental abatement, the new rule opens up more opportunity for activities that address hazards in homes through assessments of asthma and lead poisoning risk in individual homes and the provision of educational materials to families about risks, treatments, and remediation options.



services that remediate environmental concerns such as lead abatement.⁵⁹ Despite the constraint on using Medicaid funds for actual environmental abatement, the new rule opens up more opportunity for activities that address hazards in homes through assessments of asthma and lead poisoning risk in individual homes and the provision of educational materials to families about risks, treatments, and remediation options.

The Role for Affordable Housing Providers

Many affordable housing organizations currently work to improve the quality of affordable housing and eliminate home environmental hazards such as lead paint, mold, and rodents. These organizations may now be able to seek Medicaid funding for some of the work they currently do in the form of individual home assessments and education if allowed within their state guidelines. If not, these organizations and advocates can work with their state Medicaid agency to incorporate reimbursement of home assessment services, per CMS approval, in order to further the goal of preventing serious asthma incidents and lead poisoning.

Before the July 2013 rule change, the Texas state Medicaid agency explored widening its provider reimbursement policy to improve its lead poisoning prevention efforts. In 2011, the Texas Medicaid agency, at the urging of the Texas Childhood Lead Poisoning Prevention Program (TXCLPPP) in the Texas Department of State Health Services, determined that TXCLPPP was eligible for Medicaid reimbursement for its lead risk assessment activities.⁶⁰ TXCLPPP works with pediatricians and other health care providers to conduct blood tests on children under the age of six to detect for lead and then provide

education to families about treatment and lead exposure prevention. After the Texas Medicaid agency determined that environmental lead investigations carried out by TXCLPPP fell under the authority of the Medicaid state plan, it made TXCLPPP an authorized Medicaid provider. TXCLPPP now receives reimbursement for its environmental lead investigations (ELI) for children, which, in addition to the blood tests and education about lead risks and remediation options, includes testing for the source of the lead in a home.⁶¹ TXCLPPP is not fully reimbursed for the entire cost of conducting ELIs; however, the partial reimbursement supports the sustainability of its overall funding for the program.⁶² Many housing organizations across the country already work to reduce the presence of lead and asthma triggers in homes through home assessments, education, and helping low-income families access grants to conduct lead and environmental remediation. Now that non-medical practitioners can be reimbursed by Medicaid for services recommended by physicians, public health agencies that are typically responsible for testing for lead in children can contract with housing organizations that have the capacity to conduct tests for lead exposure and other health risks in the homes of low-income families. These housing organizations can also help families with serious lead or asthma risks to access resources to remediate their health risks and offer information about reducing their risks. Housing organizations can also pursue certification as Medicaid providers in states that reimburse home lead investigations in order to diversify funding for their existing activities. The broadening of Medicaid provider eligibility also expands the types of health-related activities, such as wellness education, which affordable housing organizations already provide, that might be reimbursable by Medicaid.

Older Adults

The number of people age 65 and older in the U.S. is projected to nearly double between 2012 and 2050, posing a major challenge to efforts to contain long-term care spending.⁶³ Nearly 40 percent of older adult households have a member with a disability, and that number rises to 65 percent for households headed by someone 85 or older.⁶⁴ Older adults with a disability are likely to require long-term services and supports which are very costly, particularly when given in institutional settings such as nursing homes.⁶⁵ Only about a third of older adult Medicaid beneficiaries receive long-term care; however, their long-term care services account for almost 90 percent of all Medicaid spending on older adults.⁶⁶ In order to achieve one of the ACA's goals of harnessing Medicaid spending, states are looking for ways to shift away from mostly offering long-term care in institutional settings to caring for more individuals, of all ages, in their homes and communities. The ACA makes it easier for states to do this by enhancing states' ability to use Medicaid funds to offer HCBS services without Medicaid waivers in order to help more older adults age in place even if they require long-term care.

1915(i) HCBS State Plan Option

In 2005, CMS authorized the 1915(i) HCBS state plan option that allowed states to adopt HCBS to their state plans instead of seeking individual HCBS waivers. The 1915(i) HCBS state plan option eliminated the requirement that HCBS programs be cost neutral and that individuals require an institutional level of care, creating

more flexibility for states than HCBS waivers.⁶⁷ However, few states adopted HCBS to their state plans because they were not allowed to target HCBS programs to specific populations, include individuals with incomes above 150 percent of the FPL or individuals who did not require an institutional level of care, and were limited in the kinds of HCBS services that could be offered.⁶⁸ Few states had the capacity to offer the wide array of HCBS services needed by Medicaid beneficiaries with very different health needs on a statewide basis. The ACA changed the 1915(i) state plan option to allow states with the HCBS state plan option to target specific services to a particular population, offer HCBS services to individuals with incomes up to 300 percent of FPL in certain circumstances, and offer the same array of services allowed in HCBS waivers.⁶⁹ As of March 2015, 17 states have added home and community-based services to their Medicaid state plans.⁷⁰

Community First Choice Option

The Community First Choice Option (CFC) is a Medicaid state plan option, similar to HCBS and created by the ACA, that states can choose to include in their state plans to provide HCBS attendant care services to individuals who need the level of care offered in institutions and who have incomes at or below 150 percent of the FPL.⁷¹ Unlike the HCBS state plan option, states receive an additional six percent FMAP for CFC services. CFC services must include assistance completing activities of daily living and instrumental activities of daily living and health tasks.⁷² States can also opt to include additional services such as “transition costs” for individuals moving out of institutions that can be first month's rent, utility payments and deposits, and basic household items.⁷³ CFC services must be “person centered,” according to CMS, and give patients influence in hiring a personal attendant and making other care decisions. As of December 2014, eight states have adopted the Community First Choice option to their Medicaid state plan.⁷⁴

The Role for Affordable Housing Providers

One of the major obstacles for individuals who want to move out of institutions and receive long-term services and supports in their community is finding and maintaining affordable housing. Affordable housing providers can collaborate with health care providers to educate states on the need for more affordable housing in order to care for more older adults using HCBS and CFC instead of relying on nursing homes. In Iowa, HCBS service providers found that the lack of



Connecting homeless individuals to stable housing and health care services can improve their wellbeing and reduce emergency room and hospital visits.



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affordable housing was a barrier for people who want to leave or delay moving into nursing homes and other institutions and live in the community with the support of HCBS programs.⁷⁵ These individuals often faced very lengthy waits for housing units with federal subsidies, such as public housing or Housing Choice Vouchers. To address the need for affordable housing among people receiving HCBS services as they waited for units with federal assistance, Iowa created a state-funded rental subsidy program administered by the Iowa Housing Finance Authority and specifically targeting HCBS recipients.⁷⁶ Receiving these rental vouchers enables individuals to pay no more than 30 percent of their income on housing and to remain in or transition to their communities and utilize HCBS programs instead of receiving care in an institution.

Established in 2005 and extended until 2020 by the ACA, Money Follows the Person (MFP) is a Medicaid program that facilitates the transitions of adults out of institutions and into the community. Because of the lack of affordable housing for those adults, some MFP providers have begun offering participants housing counseling services to locate affordable housing and resolve barriers to eligibility.⁷⁷

Affordable housing providers can learn from the work in Iowa and efforts by MFP providers in order to work with HCBS and CFC service providers to advocate for state or local funds to house HCBS and CFC recipients and offer more long-term care and support in community settings.

Homeless and At-Risk Individuals

Many homeless individuals, particularly those who are chronically homeless, have complex health needs and rely on costly emergency room visits to receive health care treatment.⁷⁸ Connecting homeless individuals to stable housing and non-emergency health care services can improve their wellbeing and reduce emergency room and hospital visits.⁷⁹ A series of studies have found that helping chronically homeless individuals enter supportive housing results in lower emergency care

Many homeless individuals have complex health needs and rely on costly emergency room visits to receive health care treatment.

spending and better health outcomes. In Denver, for example, a 2006 study by the Colorado Coalition for the Homeless found that housing chronically homeless individuals in supportive housing resulted in an average of \$31,545 of emergency services savings per person over two years.⁸⁰ States that have chosen to expand Medicaid eligibility to extend coverage to adults without dependent children or a qualifying disability will make all homeless individuals eligible for Medicaid. In addition to expanding Medicaid coverage, many states are considering ways to better serve high-needs populations, like the homeless, to achieve better health outcomes at lower costs to Medicaid.



Photo courtesy of Ari Burling and courtesy of Magnusson Architecture & Planning

Investment of Health Care Funds in Supportive Housing Construction

As discussed earlier, even prior to the passage of the ACA, states had the ability to use Medicaid waivers to pursue health care reform initiatives. In addition to giving states flexibility through Section 1115 demonstration waivers to conduct demonstration projects utilizing new programs or models, CMS also issues grants through the new State Innovation Model program, created by the ACA, to fund state efforts to develop new payment models for the Medicaid, Medicare, and CHIP programs. Several states use 1115 demonstration waivers to manage innovative programs to deliver long-term services and supports programs for older adults and adults with disabilities. Some of these programs offer housing supports in the form of help locating affordable housing and paying for some transitional housing costs such as security deposits and initial utility bills.

New York is one state that began implementing major changes to its health care system and Medicaid program prior to the ACA and provides an example of how greater flexibility in the provision of health care can lead to innovative and effective models that combine housing and health care services. In 2012, New York State developed a Medicaid reform plan using a Section 1115 Medicaid demonstration waiver. In 2014, the state also received a CMS State Innovation Model grant to help fund its reform planning and implementation efforts. New York State's health reforms include increased reliance on community-based and holistic approaches to patients' needs, with the goal of reducing avoidable spending on hospital use by 25 percent.⁸¹ The state's health care reform plan includes a series of changes in the Medicaid payment structure by investing in the creation of health homes, training for the long-term care workforce, and other Medicaid Redesign Team (MRT) projects, along with basing Medicaid payments on the outcomes of new health care provider collaborations formed to meet community health needs in the state's Delivery System Reform Incentive Payment Program. These reforms are anticipated to result in approximately \$17 billion

in Medicaid savings in New York over the course of five years with the state's portion of the savings totaling \$8 billion.⁸²

New York has decided to use some of its portion of the anticipated Medicaid savings to expand supportive housing as a key element of its health care reform initiatives. In its MRT Supportive Housing Initiative, the state has directed \$260 million in funds for FY 2015-16, in addition to \$86 million in FY 2013-14, for the construction of affordable supportive housing for individuals with complex and expensive health needs, particularly targeting the homeless. The MRT Supportive Housing Initiative acknowledges the critical role that stable housing plays in supporting health and wellbeing.⁸³ This funding includes operating subsidies for supportive housing providers to offer supportive services to homeless individuals or individuals at risk of homelessness, older adults, and HIV-positive individuals.⁸⁴

The Role for Affordable Housing Providers

Supportive housing providers in New York have an unprecedented opportunity to engage with the state's Medicaid program through the MRT Supportive Housing Initiative to use Medicaid funds to expand the supply of permanent supportive housing in the state and better address the health needs of homeless and other individuals. In the initial round of funding for 2013-14, up to \$400,000 in capital funds grants and rental and operating subsidies were awarded to help fund the construction of 12 new buildings with 483 supportive housing units or sustain existing supportive housing units for Medicaid health homes participants.⁸⁵ The supportive housing providers who received the capital funds, rental, or operating subsidies must partner with a health home organization to coordinate the care and services for residents.⁸⁶ Recipients of the MRT capital funds will need to obtain additional funding to complete construction and will likely rely on traditional sources of funding for affordable housing construction and rehabilitation.

One of the buildings being constructed with MRT Supportive Housing Initiative capital funds is the Creston Avenue Residence located in the Bronx. Volunteers of America-Greater New York and The Housing Collaborative, LLC have partnered to develop the building and utilized a four percent Low Income Housing Tax Credit and tax-exempt bonds from the New York state housing finance agency, in addition to other loans.⁸⁷ The building reserves 42 units for homeless adults and families eligible for health home enrollment, 8 units for disabled veterans, and 16 units for households with incomes at or below 60 percent of the area median.⁸⁸

The MRT Supportive Housing Initiative will also help to evaluate the impact of increasing supportive housing investments in addressing complex health needs among homeless and other high-health needs populations. Positive outcomes in New York can be a tool to help affordable housing advocates and developers push for similar initiatives in their states. It can also help to make the case for greater consideration for the role of housing in the national health care reform movement.

What are the Major Challenges to Seizing New Housing and Health Opportunities?

The ACA's changes to the Medicaid system and other health reform initiatives have created many opportunities for affordable housing providers and organizations to collaborate and cooperate with health organizations to support better health outcomes among low-income households. However, affordable housing providers that are interested in pursuing these opportunities for collaboration or funding from health organizations for Medicaid beneficiaries will have to overcome some major hurdles.

1. Navigating state Medicaid systems. While many affordable housing providers offer services to residents that ultimately help achieve the goals of the ACA by promoting better health, few housing providers are authorized to be reimbursed for these services by state Medicaid programs. With the exception of New York's MRT initiatives and some programs that provide support for seniors to transition out of institutions, Medicaid funds cannot be used to pay for housing. Affordable housing organizations will have to educate Medicaid agencies about the services they offer that align with Medicaid services and the potential for housing-related investments to yield health care savings. It may take a great deal of work to connect with state Medicaid agencies to learn how services offered by housing groups overlap with reimbursable services and pursue certification as a Medicaid services provider. Within a state, there is often variation in how health care is delivered to certain kinds of patient populations, with medical and behavioral health care being delivered and paid for in different ways, for example. Several MCOs, ACOs, and health homes may operate in different regions around a state and target specific populations. Affordable housing organizations will have to determine which health entities serve their residents and how the different entities operate in order to initiate partnerships with them.

2. Effectively communicating and collaborating with health care providers. For most affordable housing providers, it may not be practical to become a Medicaid service provider to receive Medicaid reimbursement due to their limited capacity. These affordable housing providers will have to approach organizations like ACOs and health homes that are eligible for Medicaid reimbursement, or other kinds of health care organizations, and explain how they would benefit from the services that many affordable housing organizations provide. In order to secure funding from these organizations, or to form a partnership to have the health care organization serve their residents, affordable housing organizations must learn to speak the language of health care organizations and establish the value housing providers can offer to achieve positive health outcomes

and lower health care costs. In many cases, ACOs and health home agencies will want to ensure a return on their investment and want evidence of cost savings that housing investments will achieve. There are also challenges to developing and disbursing appropriate legal waivers to residents and patients to allow information and data sharing between health and housing organizations, which are essential for facilitating effective cooperation.

3. Ensuring compliance with the nuances of Medicaid systems in different states. While this report provides an overview of recent changes to the Medicaid system, every state's Medicaid program is different. States have discretion in determining what kind of services are eligible for Medicaid reimbursement. Whether an affordable housing organization wants to pursue authorization as a Medicaid provider or propose a partnership with an ACO, health home, or other health care organization, housing organizations that work in multiple states will have to navigate the different Medicaid services available in each state. This could require a great deal of capacity to negotiate with several Medicaid agencies or health care organizations in order to pursue potential funding and partnerships.

Practical Guides for Pursuing Housing and Health Collaborations

LeadingAge

Housing and Health Care:

A Toolkit for Building Partnerships

A step-by-step guide on how to approach health organizations to propose a partnership

www.leadingage.org/housinghealth/

National Center for Healthy Housing

Medicaid 101 and Pathways to Reimbursement

A collection of resources that explain Medicaid policies and describe options for Medicaid reimbursement for healthy housing services

<http://www.nchh.org/Resources/HealthcareFinancing/Medicaid101.aspx>

Stewards of Affordable Housing for the Future

Health and Wellness Outcomes Measurement

A report examining services commonly offered by affordable housing providers that are highly valued by health care organizations

www.sahfnet.org

Next Steps

Housing and health care have traditionally been disconnected, and separate public policies have been adopted to meet the housing and health care needs of low-income individuals and families. However, that perspective is changing. Affordable housing providers and health care professionals increasingly understand the importance of stable and affordable housing in supporting the health of low-income individuals. Many affordable housing providers offer a range of services designed to improve the wellbeing of their residents; however, lack of funding and capacity often limit their impact. The new approach to health care brought about by the ACA and the flexibility associated with changes to the Medicaid program highlight avenues through which affordable housing providers may be able to access increased or sustainable funding for services they already provide or form partnerships with health care providers to address the more complex health needs of their residents.

Identifying opportunities created by the ACA and Medicaid reform is the first step in the process of using affordable housing as part of a more comprehensive and efficient health care strategy. Looking forward, the affordable housing sector must help the health care sector better understand the value of housing organizations

as stakeholders in supporting the health and wellbeing of low-income individuals of all ages and health needs. The next steps for affordable housing organizations are to make connections with the health care community to share information; to promote housing's role in the health of individuals, families, and communities; and to learn how they can help implement the provisions of the ACA and expanded Medicaid to improve the quality of life for low-income individuals and families around the country.

Looking forward, the affordable housing sector must help the health care sector better understand the value of housing organizations as stakeholders in supporting the health and wellbeing of low-income individuals of all ages and health needs.

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Any opinions expressed in this report are those of the author only and do not represent the the views of the reviewers. Any errors or omissions are the responsibility of the author and the Center alone.

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Formed in 1931, the nonprofit National Housing Conference is dedicated to helping ensure safe, decent and affordable housing for all in America. As the research division of NHC, the Center for Housing Policy specializes in solutions through research, working to broaden understanding of America's affordable housing challenges and examine the impact of policies and programs developed to address these needs. Through evidence-based advocacy for the continuum of housing, NHC develops ideas, resources and policy solutions to shape an improved housing landscape.



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