



# Federal and State Collaboration to Improve Health Through Housing

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State and federal policymakers increasingly acknowledge that health is difficult to achieve and maintain for people without a stable home. Numerous studies show<sup>1</sup> that housing and housing supports can help improve and maintain the health of vulnerable populations, while lowering hospital and other costs shouldered by state and local governments. Providers of affordable housing also benefit when their residents are healthy, stable, and supported. Addressing health and homelessness in tandem also enhances state and federal efforts to reduce health disparities. Writing in the online JAMA Forum, Dr. Howard K. Koh said, "...addressing the medical issues of homeless people is the health equity challenge of our time."<sup>2</sup>

In December 2016, federal and state policymakers examined these issues at a meeting convened in Washington, D.C., by the National Academy for State Health Policy (NASHP) with support from The Commonwealth Fund. The goal of the meeting was to identify concrete policy recommendations and actionable steps to align health and housing programs to ensure that people with high service needs receive the housing and supportive services they need to become and stay healthy. This report summarizes their findings and recommendations.<sup>3</sup>

## Background

A 2013 CMCS bulletin examining Medicaid super-utilizers identified homelessness as a risk factor associated with "high, preventable costs." It also found 5 percent of Medicaid beneficiaries account for 54 percent of expenditures, with 1 percent of beneficiaries accounting for 25 percent of expenditures.<sup>4</sup> Stably housing certain populations has been shown to reduce health care costs. For example, a study of 145 Oregon affordable housing properties and an Oregon Coordinated Care Organization (CCO) found that Medicaid expenditures declined by 12 percent after beneficiaries obtained affordable housing. Recently housed residents visited hospital emergency departments 18 percent less—and visited primary care providers 20 percent more—than the previous year.<sup>5</sup>

Policymakers who want to maximize the effectiveness of Medicaid dollars are interested in housing low-income families who have fallen on hard times, and in housing high-cost, high-needs beneficiaries. Housing families before parents and children slide into a life of homelessness and its attendant health problems can positively impact two generations at once and prevent expensive health interventions for years to come. Housing high-cost, high-needs Medicaid beneficiaries whose unstable housing and compromised health drives much of current Medicaid spending is also a priority, as is housing people at risk of institutionalization or transitioning out of institutions. How to allocate scarce resources to maximize the effectiveness of federal and state investments is a key question facing health and housing policymakers.

However, allocating resources is only part of the equation. Helping a high-cost, high-needs Medicaid beneficiary, or a family in need of stable housing, medical care, and social services, often means helping them navigate a bewildering array of fragmented systems. Rather than working as one streamlined system to fund a total plan of services for a person or family in need, housing and health programs use separate eligibility criteria and different terminology to determine who receives which services. These differences in eligibility standards can lead to challenges prioritizing recipients of available supports. At worst, inadequately aligned health, housing, and social services programs could create perverse incentives for those they aim to help,<sup>6</sup> or allow eligible beneficiaries to get lost in a bewildering system and ultimately fail to benefit from the services they need.

## Summary of Recommendations

- **Rigorously evaluate supportive housing and health demonstration programs**, and disseminate findings. Strengthen successful programs and streamline the renewal process for Medicaid waivers with proven success at meeting ongoing needs.
- **Adopt policies that foster promising models for cross-sector, cross-agency state and federal collaboration**, based on proven techniques from current projects and demonstrations, such as the U.S. Department of Housing and Urban Development (HUD) Section 811 Supportive Housing for Persons with Disabilities Project Rental Assistance (PRA) Demonstration Program,<sup>7</sup> and the HUD-U.S. Department of Veterans Affairs (VA) Supportive Housing (HUD-VASH) program.<sup>8</sup>
  - Such policies could include holding state housing and Medicaid agencies jointly accountable for shared outcomes, or requiring agencies to build shared governance structures to participate in a program or demonstration.
- **Review, revise and reauthorize the HUD Section 811 Supportive Housing for Persons with Disabilities PRA Program.** While the HUD Section 811 PRA program has faced some criticism for the slow pace of implementation, some state policymakers find the program valuable and worthy of emulation with some policy changes.
- **Encourage incoming HUD and U.S. Department of Health and Human Services (HHS) secretaries to meet** as soon as possible to develop strategies to ensure policy coordination between housing and health, such as developing housing vouchers and other programs designed to work with Medicaid and Medicare.
- **Align Centers for Medicare & Medicaid Services (CMS) and HUD policies** to encourage state Medicaid agencies to support health-related housing services so HUD can reallocate its funding for services to increase available rental subsidies.
  - If Medicaid pays for supports such as those outlined in the June 2015 Center for Medicaid & CHIP (CMCS) services bulletin, “Coverage of Housing-Related Activities and Services for Individuals with Disabilities,”<sup>9</sup> HUD could reallocate funds currently spent on tenant supports (such as the service coordinators funded by Section 202 Supportive Housing for the Elderly)<sup>10</sup> to create more affordable housing units.
- **Enact policies that support local or statewide property owner/manager risk mitigation funds**, to which housing providers can apply for reimbursement for damage to their properties.<sup>11</sup> Communities with these funds have found them to be helpful in engaging property owners and managers in efforts to combat homelessness, according to the U. S. Interagency Council on Homelessness (USICH).<sup>12</sup>

- **Minimize “premium slide”<sup>13</sup> to incentivize Managed Care Organization (MCO) investment in health and housing.** Some state policymakers recommended modifying the calculation of capitation rates and medical loss ratios for Medicaid MCOs in order to halt or minimize the payment cuts known as “premium slide” that result from decreased hospital and emergency department use caused by successful housing and upstream prevention initiatives. Other attendees agreed that capitation rates should allow for investment in upstream prevention, but believed that capitation rates should come down if costs come down, and that these investments should be incentivized in other ways, such as through the MCO contracting process.
- **Strategically use Medicaid managed care contracting and the Qualified Allocation Plan process** to encourage MCOs and housing developers to align their projects with a state’s health and housing goals.
- **Collect and share data across sectors** to ensure that information is available across programs to facilitate data-driven hotspotting,<sup>14</sup> resource targeting, and outcomes assessment.
- **Collaboratively develop a housing stability quality measure** to align cross-sector efforts with shared outcomes goals.
- **Braid funding sources to support a health and housing agenda**, and explore additional funding streams such as private and philanthropic investment in social impact bonds or pay-for-success programs.

## A Cross-Sector and Cross-Agency Task

The task of assuring the health of vulnerable populations and providing health care, housing, and housing-related services (such as support with finding and applying for housing) currently falls to multiple federal and state agencies. The cross-sector nature of these efforts can make it difficult for state and federal healthcare and housing policymakers to align and coordinate efforts to maximize their effectiveness, minimize gaps in services, and operate more efficiently. Nevertheless, many state and federal policymakers recognize housing as an important social determinant of health and are working to align efforts in this area. For its part, HUD uses a coordinated entry system with a no-wrong-door approach to housing and homeless services.<sup>15</sup> Through the Continuum of Care (CoC) program, HUD encourages local homeless service planning entities to work together, and encourages local CoCs to work with Medicaid agencies to meet permanent supportive housing needs identified through the coordinated entry process.<sup>16</sup>

### Recommendation:

- The incoming HUD and HHS secretaries should meet early in the new administration to develop strategies to ensure policy coordination between housing and health, and familiarize themselves with current federal, state, and local efforts to address these interconnected issues. They can also discuss the need to develop housing vouchers and programs designed to align Medicaid and housing goals.

Some Medicaid rules currently impact housing. For example, the Home and Community Based Settings (HCBS) final rule requires that beneficiaries have a choice regarding the services they receive and who provides them. The rule also encourages integrated settings for beneficiaries by subjecting to heightened scrutiny settings that isolate beneficiaries from the broader community, as well as those providing inpatient treatment or attached to a public institution.<sup>17</sup> The U. S. Supreme Court’s 1999 Olmstead decision prohibited segregation of people with disabilities, and, as the HHS Assistant Secretary for Planning and Evaluation (ASPE) noted, has implications for states seeking to address the housing needs of homeless people with disabilities.<sup>18</sup> State Medicaid programs are also required to protect the right

of beneficiaries to receive their services from any qualified and willing provider, which could complicate initiatives that rely on beneficiaries receiving care from an on-site provider.<sup>19</sup>

### Recommendation:

- Align CMS and HUD policies to encourage states to fund health-related housing services, and HUD to reallocate its funding for services to increase rental subsidies. Such coordination permits both sectors to maximize efficiency by playing to their own strengths and expertise.
  - HUD could reallocate its money spent on tenant supports (such as the service coordinators paid for with Section 202 Supportive Housing for the Elderly program funds)<sup>20</sup> to develop more housing units or rental subsidies if state Medicaid programs paid for supports such as those outlined in the June 2015 CMCS bulletin, “Coverage of Housing-Related Activities and Services for Individuals with Disabilities.”<sup>21</sup> To facilitate this strategy, policymakers could also advocate for continued support for the payment policies described in the CMCS bulletin.

Medicaid officials are concerned about the cost of providing care to beneficiaries with complex needs, and increasingly acknowledge that stable housing will help some beneficiaries become and stay healthy. Housing officials grapple with how to allocate scarce housing resources, and want to ensure that their residents receive the supports they need to become and remain stable tenants. Housing providers may prioritize people other than the high-cost, high-need Medicaid beneficiaries whom health leaders may most want to house. Differences in prioritized populations are exacerbated by the fact that the health and housing sectors use different income thresholds to determine eligibility for their programs, and different language to describe populations and services. For example, support services in the housing sector may refer to tenancy supports such as assistance searching for housing or interacting with landlords, while the health care sector generally focuses on physical and behavioral health supports, as well as services designed to improve life skills for daily living. The definition of “homeless” can also vary by program or sector (see **Table 2**).

### Recommendation:

- Review, revise, and reauthorize the HUD Section 811 Supportive Housing for Persons with Disabilities Project Rental Assistance (PRA) Program. While the HUD Section 811 PRA program has faced some criticism for its slow pace of implementation, a number of state policymakers find the program valuable and worthy of emulation.
  - What it does: Program funds are intended to support affordable housing and supportive services for nearly 4,600 extremely low-income people with disabilities.<sup>22</sup> In February 2013, HUD announced the first Section 811 PRA awards to 13 states. In March 2015, HUD announced a second round of awards to 25 state housing agencies totaling \$150 million in rental assistance. Funds for rental assistance are awarded to states that set aside units in buildings funded through the Internal Revenue Service (IRS)’s Low-Income Housing Tax Credits (LIHTC) or other public sources.<sup>23</sup>
  - Whom it serves: No more than 25 percent of units in a building may be set aside for persons with disabilities. Program participants must be extremely low-income, and at least one adult household member must have a disability. Tenants pay a percentage of their income toward their rent and utilities.<sup>24</sup> Program participants are not required to participate in services.

- **How it innovates:** Successful Section 811 PRA program applications must include an Inter-Agency Partnership Agreement<sup>25</sup> between state housing, Medicaid, and health and human services agencies, which provides a formal structure for agencies to collaborate on identifying and reaching out to target populations, and on making appropriate services available for residents. Federal agencies modeled this cross-agency collaboration, with HHS providing feedback on the HUD Notice of Funding Availability, and staff of HHS agencies helping review applications.<sup>26</sup>

Policymakers identified strengths of Section 811 PRA program:

- The program helped build states' capacity to manage waiting lists for affordable housing, and helps states monitor the reasons property owners reject housing applicants. One policymaker credited the Section 811 PRA program with spurring development of an online waiting list, which is now used for other housing programs.
- The Section 811 PRA program requires property owners to provide a written reason for rejecting an applicant. If a rejection was related to an applicant's disability and subject to the Fair Housing Act, a service provider may apply for a reasonable accommodation request on behalf of the prospective tenant.<sup>27</sup> The written rejection rationales can help states track the reasons for rejection, and the frequency and outcomes of reasonable accommodation requests.

The Section 811 PRA program spurred some states to take an active role in approving property owners' tenant selection plans. HUD requires tenant selection plans to outline eligibility requirements and specify a procedure for choosing applications from the waiting list, including any preferences that will affect tenant selection.<sup>28</sup> The program requires property owners to adopt tenant selection plans and other policies that support program goals, and requires owners to notify applicants of the reasons for rejection. The state housing agency chooses properties to participate based on how well their tenant selection plans align with the program's priorities and eligibility criteria. States can also require properties to modify their existing tenant selection plans in order to participate in the program.

Recommendations for the HUD Section 811 Supportive Housing for Persons with Disabilities PRA Program include:

- **Allow greater flexibility on the move-in timing of housing units.** Timing can be an issue for states seeking to house potential tenants who are transitioning from institutions. Units are often not available for occupancy on the precise day a potential tenant is discharged, because states need to place available units into service immediately. State flexibility to hold units until a tenant is discharged from an institution would be helpful in serving the prioritized population. Similarly, some state policymakers would appreciate the flexibility to move a person into a larger unit than they qualify for in order to meet the urgent needs of the target population. Currently states are prohibited from underutilizing units, unless, for example, an extra bedroom is required as a reasonable accommodation.<sup>29</sup> However, allowing underutilization of publicly funded housing is not supported by some federal policymakers.
  - Policymakers could use the Qualified Allocation Plan (QAP) process or other policy levers to incentivize developers to create more one-bedroom units, to increase the opportunities for housing individuals transitioning out of hospitals or institutions.
  - States with Medicaid managed care could consider working with MCOs to hold open rental units when necessary, or make up the difference in rent when only a two-bedroom apartment is available at the moment a single tenant transitions out of an institution. This sort of

investment by MCOs could avert criticism resulting from using public dollars to allow vacancy in publicly funded housing. However, this approach could also create disincentives for the development of one-bedroom units, and possibly lead to “premium slide.”

- **Develop a coordinated access point or universal waiting list** to be used by multiple housing programs. States could build on the waiting list management techniques and infrastructure developed through the Section 811 PRA program to develop a single waiting list serving multiple programs. The single waiting list could:
  - Track current and expected vacancies in rent-assisted housing units, group homes, and other cross-program and cross-agency settings in one joint database to help state officials maximize the use of available units and plan around the waiting list.
  - Educate the health sector about how the housing sector manages its waiting lists, and the importance of identifying prospective tenants ready to fill units that become available.
- **Provide guidance and flexibility to states on the 25 percent cap** on units for people with disabilities, especially for scattered-site projects. The statute<sup>30</sup> says that for projects that participate in the Section 811 PRA program, “the total number of dwelling units in any multifamily housing project” set aside for people with disabilities cannot exceed 25 percent. The “projects” could be scattered-site, with 50 separate properties defined as one “project” subject to the 25 percent cap. According to some policymakers, the cap disincentivizes the creation of scattered-site models, and prevents the use of some scattered-site units that truly are integrated into the community. More guidance to states would be helpful, as some federal policymakers believe the issue is resolved for scattered sites.
- **Allow states to pay property owners market rates without penalty.** The Section 811 PRA program awarded states points on their applications for using program funds to pay less than full fair market rent.<sup>31</sup> States are awarded points for using 811 funds to subsidize rents at levels as low as 30 percent of area median income affordability. State policymakers were concerned that below-market and even 100 percent market rents were not enough to attract the participation of property owners, and some expressed a desire to use the funds to pay for rents slightly higher than market in some areas to incentivize owner participation. Also, fair market rents are based on data that often lag real-time rents.<sup>32</sup>
  - However, higher reimbursements to property owners would decrease the total amount of rental subsidies available, unless additional federal housing funds were available. Policymakers might consider braiding funding sources to make up for shortfalls in payments to property owners, as discussed later in this report.
- **Impose a timeline for owners to respond to requests for reasonable accommodation.** Such a timeline would help state policymakers ensure that the process is functioning properly and that owners are accountable for their responses to reasonable accommodation requests.
  - For example, Texas Administrative Code requires a response to requests for reasonable accommodation within, “a reasonable amount of time, not to exceed 14 calendar days,” although 14 days may be too long in some cases.<sup>33</sup>

## Who is Low-Income?

State and federal housing and health policymakers often address the housing and health needs of the same populations: low-income individuals who are homeless or at risk of becoming homeless. Particularly in Medicaid expansion states, where Medicaid programs can serve single, childless adults with incomes up to 138 percent of the federal poverty level,<sup>34</sup> there is significant overlap between beneficiaries of Medicaid and subsidized and supportive housing programs. Single individuals with a history of homelessness may also be included in Medicaid disability eligibility even in non-expansion states.

However, housing programs and Medicaid use different eligibility criteria, so the populations they serve do not always overlap.

Income thresholds for HUD rental assistance programs vary by location, with public housing authorities required to spend 75 percent of their Housing Choice Vouchers (formerly known as Section 8) on “extremely low-income” applicants, defined as people whose household income is generally not more than the higher of the federal poverty level or 30 percent of area median income (AMI).<sup>35</sup> Families with incomes exceeding 50 percent of the area median income would generally not be eligible for Housing Choice Vouchers.<sup>36</sup> Thus, eligibility for housing subsidies varies from place to place, while Medicaid income thresholds in expansion states are standard nationwide.<sup>37</sup> Proposals to revise how the federal government pays for Medicaid may provide states flexibility in benefit design; on the other hand, the proposals could curtail state capacity to serve some current Medicaid beneficiaries.

**Table 1** compares the Medicaid eligibility threshold for a single person in two Medicaid expansion states to the “low income” and “extremely low income” thresholds for HUD Housing Choice Vouchers. Childless adults with income up to 138 percent of the federal poverty level are generally eligible for Medicaid coverage in expansion states. Medicaid in non-expansion states generally does not cover poor childless adults.<sup>38</sup> Table 1 shows that a single, childless person earning \$16,393 in 2016 in an expansion state would generally be eligible for Medicaid. He or she would likely not qualify for Medicaid coverage at all in a non-expansion state.<sup>39</sup> That same person would count as “extremely low income” for determining eligibility for HUD Section 8 Housing Choice Vouchers in Rockland County, New York, but would be well over the “extremely low income” threshold in Harlan County, Kentucky; Cincinnati, Ohio; and Franklin County, New York. Meanwhile, a person earning \$35,249 in Rockland County, New York, would be considered “very low income” by HUD guidelines and therefore could possibly be eligible for a voucher, but would be well over the income threshold for Medicaid eligibility.

The differing eligibility standards mean that a Medicaid-eligible woman in Cincinnati with complex health conditions and many medical needs may not be eligible for a PHA’s Housing Choice Vouchers because her income is too high for her to be considered “extremely low income.” She could be excluded entirely from the Housing Choice Voucher program in Harlan County because her income also exceeds even the “very low income” threshold. In another state, a disabled mother and child would receive disability benefits that slightly exceeded 30 percent of the area median income, so they would not be eligible for many assisted housing units. Note that HUD allows an earned income disregard, which would allow a beneficiary to remain in subsidized housing without an immediate increase in rent, were she to find work, even though increased income could disqualify her from Medicaid. The earned income disregard does not apply to initial eligibility determinations.

The IRS LIHTC program, which is typically administered by state housing finance agencies, also has different income thresholds. Developers have a choice: they can set aside 20 percent of units for tenants with incomes at or below 50 percent of area median gross income, or they can set aside 40 percent of units for tenants with slightly higher incomes—60 percent or less of area median gross income.<sup>40</sup>

While many high-cost, high-needs Medicaid beneficiaries—both individuals and families—are eligible for housing assistance based on income, the fact that the eligibility standards differ by program and by location could complicate efforts to target resources to the most vulnerable. Alignment between housing and health programs could be further complicated if changes to Medicaid eligibility result in coverage for fewer residents of subsidized housing.

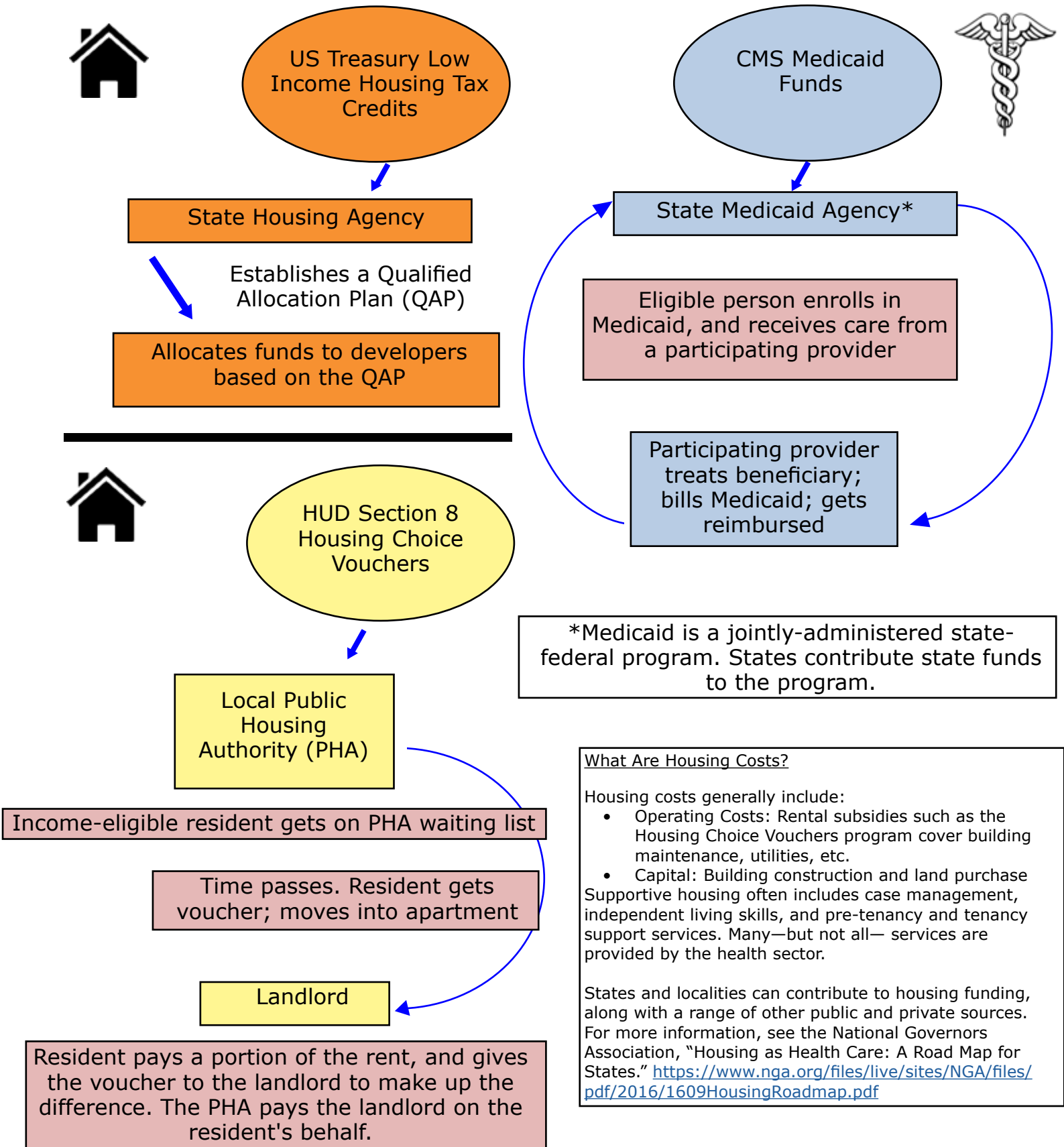
**Table 1. Medicaid and Housing Choice Voucher Income Thresholds for a Single Person**

	<b>Kentucky</b>	<b>New York</b>
<b>2016 Medicaid</b> eligibility threshold (138% of Federal Poverty Level)	\$16,394 <sup>41</sup> statewide	\$16,394 <sup>42</sup> statewide
<b>FY 2016 “Extremely low income”</b> (the higher of 30% of the area median income or the federal poverty guidelines) threshold for <b>HUD Section 8 Housing Choice Vouchers</b> <sup>43</sup> and other programs	\$11,880 in Harlan County, KY <sup>44</sup>	\$12,400 in Franklin County, NY <sup>45</sup>
	\$14,850 in Cincinnati, OH-KY-IN <sup>46</sup>	\$21,150 in Rockland County, NY <sup>47</sup>
<b>FY 2016 “Very low income”</b> (50% of the area median income) threshold for <b>HUD Section 8 Housing Choice Vouchers</b> <sup>48</sup> and other programs	\$16,250 in Harlan County, KY <sup>49</sup>	\$20,650 in Franklin County, NY <sup>50</sup>
	\$24,750 in Cincinnati, OH-KY-IN <sup>51</sup>	\$35,250 in Rockland County, NY <sup>52</sup>

One challenge to cross-sector work is understanding the funding and operations of other entities. A simplified schematic on the next page (Figure 1) shows funding flows for Medicaid, HUD Housing Choice Vouchers, and LIHTC, administered by the U. S. Department of the Treasury.



Figure 1. Funding Flow for Medicaid, Housing Choice Vouchers, and LIHTC (Simplified)



## Allocating Scarce Resources

While anyone meeting Medicaid eligibility requirements is currently entitled to enroll, the same is not true for those qualifying for publicly subsidized housing. In fact, in 2015 the Urban Institute reported, "...only 28 adequate and affordable [housing] units are available for every 100 renter households with incomes at or below 30 percent of the area median income. Not a single county in the United States has enough affordable housing for all its extremely low-income (ELI) renters."<sup>53</sup> The scarcity of affordable housing means that eligible individuals and families are often placed on waiting lists for Housing Choice Vouchers and other programs. Eligibility is determined by local public housing authorities and other entities that can prioritize certain populations on their waiting lists, such as veterans experiencing homelessness.<sup>54</sup> Eligibility is also impacted by the private housing providers who accept Housing Choice Vouchers or participate in other affordable housing programs. Property managers and landlords have their own screening processes, which often include a criminal background check. HUD guidance from April 2016 indicates that background check policies that have a "disparate impact" on certain populations could run afoul of the Fair Housing Act.<sup>55</sup> State-level health policymakers may also find it challenging to collaborate on prioritization with each of the myriad local public housing authorities<sup>56</sup> that distribute and administer housing subsidies at the local level, as well as with the other entities that participate in housing programs.

### Recommendation:

- States could use their statutory authority to align PHAs in the service of common state health and housing goals. Local PHAs are authorized through state statute, although PHAs are largely guided by HUD. States could use the authorizing legislation as a lever, and work with local PHAs to align their tenant selection process with health and housing priorities.

State and federal Medicaid and housing programs may have different priorities when it comes to deciding whom to house. When Medicaid officials think about improving health through housing, they often think of "hotspotting": meeting the housing and other health-related social needs of the few individuals whose complex, chronic needs drive them to repeatedly seek care in emergency departments and other high-cost settings.<sup>57</sup> Some officials also seek to control costs and improve outcomes by finding appropriate housing in the community for those who are institutionalized or at risk of being institutionalized. Evidence suggests that meeting the housing needs of high-cost, high-needs people can result in better care at a lower cost—an appealing proposition to health policymakers.<sup>58</sup> The HUD final rule defining "chronically homeless" can be seen as aligning with this goal. The rule, "...focuses on persons with the longest histories of homelessness, who often have the highest need," in order to "ensure that funds are targeted to providing permanent supportive housing solutions," for chronically homeless individuals and families.<sup>59</sup> The July 2016 HUD Notice CPD-16-11, "Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing"<sup>60</sup> also gives priority for permanent supportive housing to those who have spent the longest time experiencing homelessness, have the greatest need for services, and who have a disability.

For their part, affordable housing providers may prefer to rent to the low-income families on their waiting lists rather than prioritize the high-cost, high-needs individuals who they fear may damage the property and drive up building insurance costs. Lenders and investors may have similar reservations. Opportunities exist for state and federal policymakers to reconcile the interests of the health and housing sectors.

## Recommendation:

- Enact and fund policies that encourage property owners to house vulnerable populations. Supporting local or statewide landlord risk mitigation funds is one such policy. Housing providers could apply to these funds for reimbursement for damage to their properties occurring after renting to high-risk tenants, such as people who had experienced homelessness.<sup>61</sup> Such a fund could affect the willingness of PHAs and property owners to prioritize the populations whose physical and mental health stands to improve the most through stable housing.<sup>62</sup>
  - Funding could come from the Community Development Block Grant or other public or private funds.
  - The fund could also pay for tenant services and supports, so that the services would remain stable even if the tenant loses Medicaid or other insurance that previously paid for their services.
  - Assigning a Medicaid case manager to eligible tenants may also reassure property owners and help tenants receive the services they need to remain stably housed.

## Sharing Data

One barrier to the hotspotting approach is the difficulty sharing data across health and housing systems. If Medicaid agencies do not know which or how many beneficiaries are homeless, it is difficult to help meet their needs. It is difficult for housing providers to help arrange for Medicaid-reimbursable tenancy support services if they do not know if a critical mass of their residents are Medicaid beneficiaries. To address this situation, some states have built data sharing agreements into their health and housing initiatives, and work with health plans and Continuum of Care organizations on data sharing. However, agencies can be reluctant to share the data necessary to target efforts and measure their impact.

Federal agencies released a study in 2014 that matched data from HUD’s housing programs to Medicaid and Medicare administrative data to determine the feasibility of linking those datasets to “track health and housing outcomes.”<sup>63</sup> The study showed the feasibility of linking those datasets and suggested that such a link could help policymakers better understand the demographics and healthcare utilization patterns of HUD-assisted beneficiaries compared to unassisted beneficiaries.

## Recommendation:

- Enhance data collection and sharing to facilitate hotspotting, resource targeting, and outcomes assessment. Use ICD-10 codes, or other relevant data that states already collect, to avoid imposing an undue burden on states and providers. Fund and support state efforts to match Medicaid or all-payer claims data with homeless management information system (HMIS) data.
- Jointly develop a housing stability quality measure that is applied consistently across health and housing programs to align efforts to meet shared outcomes goals.

## Who is “Homeless”?

Just as the definition of low-income varies across agencies, the definitions of homelessness used to determine eligibility for programs also vary across federal and state agencies, reflecting different priorities (see **Table 2**).<sup>64</sup> States also establish their own eligibility requirements for programs. The VA’s definition of veteran, which does not necessarily include everyone who has served in the U. S. military,<sup>65</sup> is pertinent to programs serving veterans experiencing homelessness. These different definitions reflect the priorities and missions of the entities involved in funding homelessness services, so it is helpful to understand and accommodate these differences when embarking on cross-agency work or a shared cross-agency agenda.

**Table 2. Definitions of Homelessness Used to Determine Eligibility for Programs, by Agency**

<b>HUD<sup>66</sup></b>	<b>Health Resources and Services Administration (HRSA)<sup>67</sup></b>
<p>HUD’s definition of “homeless” includes people who fall into one of four categories:</p> <p>“(1) Individuals and families who lack a fixed, regular, and adequate nighttime residence and includes a subset for an individual who resided in an emergency shelter or a place not meant for human habitation and who is exiting an institution where he or she temporarily resided;</p> <p>(2) Individuals and families who will imminently lose their primary nighttime residence;</p> <p>(3) Unaccompanied youth and families with children and youth who are defined as homeless under other federal statutes who do not otherwise qualify as homeless under this definition; and</p> <p>(4) Individuals and families who are fleeing, or are attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member.”</p>	<p>The term “homeless individual” means an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations and an individual who is a resident in transitional housing.</p>

As **Table 2** illustrates, people staying with family or friends generally would not be included in the HUD definition unless they were losing that nighttime residence,<sup>68</sup> and would not be prioritized for permanent supportive housing programs—although HUD does have other programs for people who are newly homeless. However, people doubled up in the homes of others may be included in the definition of “homeless” used by HRSA-funded health centers.<sup>69</sup> These definitions reflect different ideas about whom to prioritize for housing: people who have chronically been living on the street or in shelters, or people who do not have stable housing but who, with some assistance, could be spared the experience of living on the street.

## Using Existing Policy Levers

Despite differences in priorities, eligibility criteria, and terminology, housing and Medicaid leaders currently use a number of policy levers to help meet the health and housing needs of their respective beneficiaries. State housing finance agencies can codify their priorities in their Qualified Allocation Plans (QAPs) and multifamily housing development<sup>70</sup> program rules. A number of states are encouraging housing developers to address health needs by awarding QAP points to developers applying for U.S. Treasury Low Income Housing Tax Credits (LIHTC) who articulate a plan to address the health needs of residents.<sup>71</sup> The LIHTC program allows state housing agencies to issue tax credits to fund

the construction and rehabilitation of affordable rental housing. HUD calls LIHTC “the most important resource for creating affordable housing in the United States today.”<sup>72</sup> LIHTC QAP points can be awarded for setting aside units for people with disabilities identified by state Medicaid agencies, or for adopting a tenant selection plan that aligns with state health and housing goals.<sup>73</sup> For example:

- Georgia’s QAP encourages “innovative ideas for holistic place-based approaches to integrating health and housing,” such as incorporating partnerships with health care providers or engaging tenants in healthy eating programs.<sup>74</sup>
- Illinois’s QAP awards points for amenities that encourage physical activity such as walking paths, bike parking, and basketball or volleyball courts.<sup>75</sup>
- Ohio’s QAP awards points for creative design elements such as healthy housing features, paths, and play areas. Developments serving older adults are given points for developing a strategy for aligning housing and health care services.<sup>76</sup>
- Louisiana’s QAP has for years awarded points to developers who set aside 5 to 15 percent of units for the state’s Medicaid-supported Permanent Supportive Housing program. The state started off with a 5 percent *requirement*, but the program now has sufficient developer buy-in that incentive points are used. The state is considering raising the ceiling for these set-asides to 25 percent of units in a project.
- Oregon’s QAP awards points for aligning projects with a Coordinated Care Organization’s community health improvement plan, when that plan prioritizes housing. A majority of the CCOs now prioritize housing.

### Recommendation:

- Enforce QAP program rules. If a developer is awarded points for certain activities, but fails to carry them out, the state often has little recourse. Develop and share best practices for enforcing developers’ use of the LIHTC in accordance with the QAP, such as maintaining a list of noncompliant developers, or other strategies for holding developers accountable. Noncompliance weakens the effectiveness of the QAP—and the LIHTC—as state policy levers.

Medicaid is often looked to as a key funding source to address the social determinants of health, although its use for housing is circumscribed by the statutory restriction on paying for room and board under most circumstances. A number of states have incorporated housing services into Medicaid waivers and State Plan Amendments. In June of 2015, an informational bulletin from CMCS, “Coverage of Housing-Related Activities and Services for Individuals with Disabilities,” outlined the different waivers and demonstrations states could use to fund housing-related services for some populations, indicating the agency’s support for using Medicaid to address housing and other social determinants of health. Services that could be covered for some populations include assistance with looking for and applying for housing, one-time transition expenses such as security deposits, bedding, and kitchen supplies, and help resolving disputes with landlords. Payment for room and board, monthly utilities, or food are generally not permitted.<sup>77</sup> States can also use State Plan Amendments (SPA) to address housing. For example, New York incorporated housing services into its health homes SPA by requiring health homes to work with supportive housing providers.<sup>78</sup> Health home care managers have helped place health home members in housing and worked with housing providers to identify and address early signs of crises in health home members.<sup>79</sup> For example:

- Illinois’s Section 1115 demonstration waiver proposal includes pre-tenancy and tenancy support services for people with behavioral health conditions who are at risk of becoming homeless, experiencing homelessness, or institutionalized.<sup>80</sup>
- Louisiana includes tenancy supports for permanent supportive housing as a service in its five Home and Community-Based Services waivers for the aged and disabled and people with intellectual/developmental disabilities, and as a component of its state plan Mental Health Rehabilitation benefit.<sup>81</sup>

## Medicaid Managed Care Contracting

Many states that deliver Medicaid services through MCOs are leveraging the managed care contracting process to require Medicaid MCOs to address housing, and include housing services in their capitated rates. States can leverage the request for proposals (RFP) process to move a health and housing agenda by encouraging or requiring MCOs to address housing needs in their bids. Here are some examples:

- California’s Medi-Cal 2020 Whole Person Care Pilot requires each application to include the participation of at least one managed care plan and the public housing authority for pilot projects that provide housing services. The pilots target Medi-Cal beneficiaries “who are high users of multiple health care systems and continue to have poor outcomes.”<sup>82</sup>
- Texas’s STAR PLUS program contracts with MCOs to serve individuals with disabilities, including outreach to homeless members and coordination with housing services.<sup>83</sup>
- Pursuant to a Section 1115 waiver, Oregon’s Coordinated Care Organizations (CCOs) can pay for “flexible services” to meet health-related needs, such as providing temporary housing during post-surgical recovery.<sup>84</sup> However, “premium slide” (see below) affects CCOs’ ability to scale up these services.

While some MCOs may decide that the prospect of future savings from stably housing high-cost Medicaid beneficiaries makes these investments attractive, “premium slide” is a complicating factor, according to some state policymakers. Premium slide occurs when MCOs invest in population health or upstream prevention interventions that successfully reduce hospitalizations and other utilization, and then face a cut in their premium rates in future years as a result of the lower spending. MCO investments in housing and social determinants are often treated as administrative expenses rather than as medical expenditures. When MCOs have their rates reduced as a result of investing in upstream prevention, the MCOs do not have as much money — or incentive — to invest in social determinants initiatives. Oregon’s Section 1115 Medicaid demonstration program renewal (which was approved as this paper was finalized) aims to address premium slide by building a higher profit margin into the capitation rates of high-performing CCOs that show cost reduction and quality improvement. The renewal also includes flexible services in the numerator of the medical loss ratio alongside claims costs.<sup>85</sup>

### Recommendation:

- Address “premium slide” and rate-setting for MCOs. Some state policymakers recommended changing the way MCO rates are calculated in order to promote MCO investment in health and housing. For example, some participants recommended categorizing investments in social determinants of health as medical rather than administrative services. When such investments successfully reduce utilization, MCOs rates could be set slightly higher than required by the new, lower, utilization to enable MCOs to continue to invest in the programs contributing to the reduced utilization. However, other participants believed that premiums should slide down when costs decrease. Participants generally agreed, however, that MCO rates should allow for investment in housing and upstream prevention.

## Supporting Cross-Sector Collaboration

State and federal leaders know that transforming health systems to reward value over volume requires meaningful collaboration between Medicaid, public health, state and local housing agencies, housing developers and providers, social services, the criminal justice system, healthcare providers, health systems, community organizations, and others. Policymakers also acknowledge that trust is essential for such collaborations to be effective, along with a willingness for partners to work outside their comfort zones.

On the health side, recent federal initiatives have encouraged collaboration between community organizations and state Medicaid and public health agencies. For example, the multi-payer State Innovation Model (SIM) Round Two Model Test initiative required states to include a plan for improving population health.<sup>86</sup> The Accountable Health Communities model launched by the Center for Medicare and Medicaid Innovation (CMMI) to address the health-related social needs of Medicare and Medicaid beneficiaries required applicants, who could be community-based organizations or other entities, to obtain a written statement from their state Medicaid agency promising “to participate in the applicant’s implementation” of the model. Applicants lacking such written assurances from Medicaid would not be considered.<sup>87</sup> However, the extent and nature of that support and participation in practice is still to be determined. The HUD Section 811 Supportive Housing for Persons with Disabilities Project Rental Assistance (PRA) Program, discussed earlier, is another leading example of cross-sector collaboration. HUD also has a senior-level advisor position focused on housing and services.<sup>88</sup>

HUD has also worked with the VA to address homelessness for people who are veterans. The HUD-VA Supportive Housing (HUD-VASH) program combines HUD Section 8 Housing Choice rental assistance vouchers with supportive services and comprehensive case management provided by the VA. Veterans experiencing homelessness enter the program through assessments at VA medical centers.<sup>89</sup> HUD allocates the VASH voucher funding to local public housing authorities partnering with VA medical centers. HUD and the VA jointly determine the number of vouchers given to each PHA, and jointly set performance targets for the program, such as the percent of veterans receiving HUD-VASH case management who are chronically homeless.<sup>90</sup> One policymaker said that the shared outcomes goals of HUD and the VA resulted in progress toward ending veteran homelessness. In 2016, HUD, the VA, and the U.S. Interagency Council on Homelessness announced a 47 percent decline in veteran homelessness since 2010.<sup>91</sup>

### Recommendation:

- Design a housing rental subsidy voucher program to work with Medicaid to serve high-cost, high-need beneficiaries experiencing homelessness, similar to how the HUD-VASH program is designed to work with the VA to serve veterans experiencing homelessness. In the HUD-VASH program, housing vouchers are used in conjunction with the VA’s medical and case management services. The program could be used as a model for a Medicaid and housing voucher program.

Another example of state cross-sector collaboration is Vermont’s Support and Services at Home (SASH) program,<sup>92</sup> which is part of the Center for Medicare and Medicaid Innovation’s Multi-Payer Advanced Primary Care Demonstration (MAPCP).<sup>93</sup> SASH provides coordinated in-home services to the elderly and disabled living in affordable housing and elsewhere in the community. ASPE’s second annual report found lower Medicare expenditures among participants in this program.<sup>94</sup>

If federal initiatives continue to encourage or require collaboration across state and federal agencies, defining the nature of that collaboration, providing the resources to support collaboration, and determining how to measure its results will be important to ensuring the effectiveness of such investments.

### Recommendation:

- Develop policies that foster meaningful cross-sector partnerships, such as holding state housing and Medicaid agencies jointly accountable for shared outcomes, or requiring shared governance structures in demonstration programs.

## Funding Strategies for States

In light of the scarcity of affordable housing resources and proposals to change the funding structure of Medicaid, state policymakers are considering alternative sources of funding to augment federal funding for health and housing.

- Explore braided funding. State policymakers are no strangers to the idea of combining separate funding sources to advance their goals.<sup>95</sup> Explicit guidance to states and localities encouraging them to use multiple funding sources to support health and housing initiatives could support these innovative financing arrangements. One model for such encouragement is the education sector, where the Elementary and Secondary Education Act (ESEA) asks states to encourage schools to combine funding sources, according to the Association of Government Accountants.<sup>96</sup>
  - Some states are layering rural development funds from the U.S. Department of Agriculture (USDA) into their affordable housing strategy. While some states experience challenges obtaining and sustaining USDA funding for housing, the potential benefits of these resources may merit another look. The USDA Rural Housing Service<sup>97</sup> oversees programs that provide rural rental assistance, and support rural home ownership and home repair. For example, the USDA Rural Housing Service's Multi-Family Housing Loan Guarantees supports investment in affordable rental housing.<sup>98</sup> The loan guarantees can be used in conjunction with LIHTC and a range of other federal, state, or private funding.<sup>99</sup>
  - States could also continue to leverage private and philanthropic investments through social impact bonds and Pay for Success programs,<sup>100</sup> and/or consider working with public employee groups on investing public retirement fund capital in housing.<sup>101</sup>
- Support state health system transformation investments. Some hospitals and health systems that participate in accountable care organizations or other risk-bearing accountable care structures invest in housing as a means to control costs and improve outcomes for high-risk beneficiaries.<sup>102</sup> Continued federal investment in and approval of state health system transformation models would help support the alignment of health, housing, and other social determinants of health.
- Leverage hospital investments.<sup>103</sup> The investments made by nonprofit hospitals in community benefit and community building activities in order to maintain their tax-exempt status could become a more widely used source of funding for health and housing initiatives.<sup>104</sup> Policymakers could encourage or require hospitals and other entities to include housing in their community health needs assessments or other community health assessments. States might incorporate this strategy into their community benefits standards even if the federal requirements change in a new administration.<sup>105</sup>
  - Rewarding hospitals that invest in affordable housing instead of stocks or other investments with community benefit credit for the difference in returns is one possible strategy for encouraging this sort of investment.
- Consider implementing a renters' tax credit, which could be awarded to owners of rental properties in exchange for keeping rents below a certain percentage of a low-income tenant's income.<sup>106</sup>



## Looking Ahead

Health and housing leaders work with different priorities, definitions, and data. However, this meeting demonstrated that there are points of commonality among policymakers that could be instructive for an incoming administration.

Some policymakers credit Medicaid expansion with facilitating the alignment of health and housing goals, as the expansion of Medicaid pursuant to the Affordable Care Act resulted in greater Medicaid enrollment among permanent supportive housing residents and people experiencing homelessness. What will become of the considerable state, federal, and private investments in health and housing if the Medicaid expansion is rolled back—or if federal funding for Medicaid is substantially reduced—remains to be seen.

Policymakers interested in improving health and reducing costs through housing can educate legislators and other decision-makers about the need to provide stable housing to vulnerable populations—such as the elderly, the chronically homeless, people with disabilities, and those transitioning from institutions—and the importance of Medicaid to those populations. Making the business case for housing high-needs populations, and quantifying and acknowledging the jobs created by investments in affordable housing, will also be important to garner support for existing and new initiatives. Whatever the future holds, cooperation between state and federal health and housing policymakers is essential to improving the health of the most vulnerable.

## Endnotes

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