Pay for Success Demonstrations of Supportive Housing for Chronically Homeless Individuals: The Role of Medicaid

Leighton Ku, PhD, MPH
Dept of Health Policy & Management

APPAM Conference
Nov. 2016
Many Medicaid beneficiaries are chronically homeless. Often have complex behavioral/substance use/chronic health problems. Often use EDs, admitted to hospitals, etc.

Permanent supportive housing (PSH) could help some stabilize their lives & health, reducing medical costs.

But public housing funds are limited, so some want to use Medicaid savings to help support PSH.

Could Pay for Success (P4S) programs use Medicaid savings for PSH?

Would it yield a return on investment (ROI)?
Background on Medicaid Policy

- Medicaid usually does not pay for housing, except room and board for long-term care for elderly or disabled.
- Some states support housing-related services for homeless and some have requested greater authority under waivers.
- More interest in Medicaid funding due to limited housing funding and recent Medicaid eligibility expansions.
- CMS (2015): states have option to pay for certain housing-related services but not the actual costs of housing. May use regular or waiver authority.
- But there are evidentiary and legal challenges in using Medicaid savings in P4S PSH projects.
Current P4S PSH Projects

• Being tested in demo projects, but not currently using Medicaid funding to pay investors.
• Local govt responsible for payments to investors, based on expected local savings in housing & jail costs.
• Investors work with a nonprofit housing group to establish and administer PSH project. Independent evaluations.
• Payback formulae based on stability of housing arrangements (Santa Clara, Denver) and jail days reduction (Denver).
• HUD recently funded 7 local P4S supportive housing projects (about $1 - $1.3 million each).
Evidence of Net Medicaid Savings?

- Several studies of medical care/Medicaid savings, but few provide enough detail to analyze program costs vs. Medicaid savings. ROI requires net overall savings.
- Prior projects vary in how clients are selected and treated, vary in evaluation approaches.
- Systematic reviews: PSH is a promising way to help homeless & lower social costs, but evidence is mixed.
- Studies usually show more ambulatory care, including mental health, but less ED, hospital & psych institutional use.
- A veterans study: PSH leads to higher overall medical use.
NY/NY III Supportive Housing Evaluation (2013)

Adjusted Costs per Client for Housed and Control Groups.
(Savings = the Difference in Costs)

Supportive Housing Costs = $17,566
Medicaid Savings = $935
Total Savings (Medicaid + Psych + Etc.) = $27,665
Total Net Savings = $10,100

Source: Levanon Seligson, et al., 2013
Sample includes 1695 housed & 3700 controls, drawn from eligibles.
Summary

• Overall net savings $10,100 ($27,700 savings - $17,600 costs)
• Only $935 Medicaid savings. Had Medicaid paid for all housing costs, there would be a net loss of $16,631.
• Largest savings from psychiatric institutions, but Medicaid generally does not cover this (IMD exclusion).
• One MA study showed net Medicaid savings, but weaker research design and less detail.
• Recent OR study found larger Medicaid savings, but did not report program costs.
• PSH may improve health or well-being, but evidence suggests it may not yield net Medicaid savings.
Legal Issues with Medicaid Savings

- Medicaid administered thru capitated managed care organizations (MCOs), fee-for-service (FFS) or both.
- No legal way to directly rechannel Medicaid FFS savings back to investors.
- MCOs have flexibility in use of capitation funds to pay back investors, but must account later for future rates. Typically multiple MCOs in a state.
- Alternative is to not directly involve Medicaid. Use a higher-level funding source, e.g., county board, state general fund, etc. that might have savings, but is not directly governed by Medicaid statute. This also helps if multiple local programs are involved. Current model.
Technical Quandaries

• Medicaid matching rate. Federal govt contributes at least 50%, 90-100% for newly eligible.

• Evaluating PSH programs could be difficult. Appropriate counterfactual/control group, limited samples, high variability. Potential need to link multiple data sources.

• Targeting likely to be important.

• Establishing payment formulae at outset is difficult. Might require phased approach.

• May be hard to attribute source of savings if multiple sources are used (e.g., Medicaid for supportive services, but another source for housing).
Main Issues for P4S for PSH

• No Medicaid P4S PSH examples yet.
• Medicaid doesn’t cover psychiatric hospitalizations, a major source of potential savings (some exceptions)
• No direct way to use FFS savings to pay back investors. Could use managed care, but complicated and fragmented.
• CMS does not permit direct coverage of housing costs and has rejected waiver requests to do so.
• PSH projects usually local, not statewide.
• P4S could be complicated for relatively small projects, including multiple parties and levels of government.
Alternatives Available Now

• Already ways to use Medicaid to support innovative solutions for housing the homeless.

• Medicaid programs can cover supportive services for homeless without demonstrating savings, without P4S.

• Medicaid expansions could support enroll the homeless in Medicaid to cover medical/mental health services, as well as supportive services.

• Medicaid could share data to help identify high need, potential high gain, homeless for PSH projects. Provide data to help show broad social savings.
Acknowledgments

- Supported by the Office of the Assistant Secretary for Planning and Evaluation, HHS.
- Thanks to John Tambornino, project officer (ASPE), and Paula Lantz, principal investigator (U Mich) and Sara Rosenbaum (GW) for guidance.
- Many other experts offered critical input and information.
- Views are those of the author and do not reflect views of HHS or GW.