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Ending Chronic Homelessness: Cost-Effective Opportunities for Interagency Collaboration

Ending Chronic Homelessness:

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Introduction

Faced with a difficult economic climate with high levels of unemployment and widespread home foreclosures, the Administration of President Barack Obama has created a unique opportunity to rethink and redirect fundamental policies and practices ranging from health care to regulation of the financial industry. A similar opportunity exists to change Federal homeless assistance policies and programs.

The inclusion of the "Homelessness Prevention and Rapid Rehousing Program" (HPRP), as part of the *American Recovery and Reinvestment Act of 2009,* signals the Administration's willingness to fundamentally change how the United States addresses homelessness. Instead of preserving the status quo of providing assistance to individuals and families only *after* they have become homeless, the HPRP takes a prevention oriented approach to avert a large influx into homelessness of persons whose once secure jobs and homes are threatened by the economic crisis. There is a great opportunity to build on this shift in how we seek to end homelessness in the United States.

The Administration and the Interagency Council on Homelessness will create a new agenda for programs and a new direction for homeless assistance policy. In this context, there is a need to advance a strong policy stance for cost-effective, permanent supported housing-based solutions for chronically homeless persons whose exit from homelessness is complicated by a severe mental illness, substance abuse disorder or physical disability, and co-occurrences of these conditions. There are strategies to provide cost savings in this endeavor for major Federal agencies, as research shows that chronically homeless persons placed in permanent housing significantly reduce their utilization of health services, which are often reimbursed by Medicaid or the Veteran's Administration (VA).

The potential for cost offsets and savings in the U.S. health care system is even more important amidst policymakers' efforts to reform the American health care system and contain rapidly increasing health care expenditures. Health care reform legislation passed in March, 2010 will expand Medicaid benefits to cover low-income adults without dependents. Under such an expansion all chronically homeless persons, even those not eligible for Supplemental Security Income (SSI), would become eligible for Medicaid coverage. As a result, Medicaid could be responsible for a greater part of the cost of care for chronically homeless persons, whose medical expenses in many states to date have been uncompensated, or in other states, paid by state medical assistance programs. Given that an expansion of Medicaid coverage will require a greater fiscal commitment on the part of Federal and state authorities, minimizing the utilization of preventable and expensive acute health care services by chronically homeless persons is of vital importance. Due to its demonstrated effectiveness at reducing health care service utilization among chronically homeless persons, an expansion of permanent supported housing and facilitating Medicaid reimbursement for services in supported housing are attractive policy alternatives.

Both health care reform and the presence of a new Administration also offer a unique moment for increased collaboration between agencies, including the Department of Housing and Urban Development (HUD), the Department of Health and Human Services (HHS), and the VA, to design and implement policies and programs that reduce homelessness and enhance the efficient and effective use of resources. Permanent supported housing for chronically homeless persons offers significant potential for better use of health resources and is a natural fit for collaboration among federal partners.

This paper will present the case for policies both to expand the availability of permanent supported housing for chronically homeless persons and establish practices that would make appropriate, needed and effective Medicaid services available for highly selected and targeted populations. After placing the permanent supported housing approach in the context of homeless assistance programs in the United States, we will explain the conceptual underpinnings, program elements and funding mechanisms for permanent supported housing programs. The paper will then review evidence that provides compelling justification for permanent supported housing as a strategy that can realistically end chronic homelessness and generate substantial cost reductions (at the individual client level) and offsets (at an identified population level), if not cost-savings. We will then offer a set of policy objectives that could be pursued with benefits to all concerned that have two primary goals to: 1) increase the availability of permanent supported housing and 2) establish new national policy to provide greater and streamlined access to specific Medicaid funded services for providers of supported housing.

Background

Chronic Homelessness Is Expensive

Since the emergence of widespread homelessness in the United States in the 1980s, the homeless assistance system has proven to be relatively ineffective at eliminating the problem. Instead, homelessness has become an entrenched phenomenon, with about 1.6 million Americans experiencing homelessness in a given year.[i] In part, the continued existence of large numbers of homeless persons can be attributed to housing market dynamics that have created an affordability problem so severe that 5.5 million very low-income households are forced to spend more than 50 percent of their income on housing.[ii] However, the homeless assistance system itself has also

played an unintended role in the persistence of homelessness, and of chronic homelessness in particular.

Chronically homeless persons are long-term shelter users or "street homeless," the vast majority of whom have a serious mental illness, substance abuse disorder or physical disability, and often a combination of these. According to the Federal definition shared by HUD, HHS and the VA, a chronically homeless person is defined as "an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more, or has had at least four episodes of homelessness in the past three years."[iii]

Programs and federal resources directed towards homelessness have historically been geared towards providing emergency assistance instead of permanent housing. Moreover, services for the homeless have primarily focused on serving persons only after they become literally homeless. The McKinney-Vento Homeless Assistance Act and the introduction of HUD's Continuum of Care policy have contributed to establishing a parallel social welfare system comprised of programs and services for homeless persons. Indeed, the number of available beds in transitional and longer-term homeless programs tripled between 1984 and 1988, and doubled again between 1988 and 1996.[iv] An additional 60 percent growth in the number of transitional housing programs since 1996 provides further evidence of the rapid growth of the homeless assistance system.[v] In addition, shelters have broadened their mandate beyond the provision of emergency housing and assumed more wide-ranging rehabilitative functions resulting in individuals and households remaining in temporary housing longer and at greater expense.

Regrettably, the expansion of the homeless assistance system has not produced reductions in the prevalence of homelessness, and has become quite expensive to maintain. The Federal

government has budgeted $2.6 billion in fiscal year 2009 for ten homeless assistance programs spread across a number of Federal agencies including HUD, the Department of Health and Human Services (HHS), the Department of Homeland Security (DHS), the Department of Veterans Affairs (VA), the Department of Labor (DOL) and the Department of Education (ED). While HUD programs account for the largest share of federal spending on homelessness, HHS homeless assistance programs, including Health Care for the Homeless and programs funded by Substance Abuse and Mental Health Services Administration (SAMHSA), cost more than $400 million.[vi]

In addition to direct expenditures on homeless programs, Federal and state payers of acute health care services, including Medicaid, Medicare and the VA, bear the high costs of chronically homeless persons who make relatively greater use of emergency department and inpatient medical or psychiatric care, as well as of detoxification services, jails and prisons. Indeed, in comparison to housed persons with similar characteristics, homeless persons use more emergency department services and experience greater numbers and longer lengths of inpatient hospitalizations.[vii viii ix] Acute care service utilization by homeless persons, which is frequently paid for by Medicaid and Medicare programs, the VA or by other state and local public payers, is quite expensive. One study conducted in New York found that the multi-system service use of chronically homeless persons with severe mental illness cost on average about $40,500 per person annually (in 1999 dollars).[x] Another study conducted with a sample of homeless persons with severe alcohol problems found a median annual cost of jail and shelter stays, inpatient and emergency medical services and detoxification treatment of nearly $50,000.[xi] Public payers bear the brunt of these expenses for homeless persons.

Are We Doing Enough to Create Permanent Supported Housing?

With finite resources for homeless assistance, a cost-effective intervention such as permanent supported housing has attracted interest by policymakers. The past decade has seen increased emphasis on providing permanent supported housing. Both a Federal and local policy focus on "ending" chronic homelessness through the provision of permanent housing has emerged. Since 2000, Congress has required that HUD dedicate at least 30 percent of its McKinney-Vento appropriation towards the creation of permanent housing for homeless persons. This "30 percent set aside" was preserved in the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act, legislation passed in May 2009 that reauthorized McKinney programs, and was amended to include a 10 percent set aside for permanent housing intended for homeless families, within the overall 30 percent set aside for permanent housing. Moreover, in 2003 the Bush administration prioritized ending chronic homelessness in its budget proposal. Local communities and policy makers also have demonstrated increased interest in permanent supported housing. At the encouragement of the U.S. Interagency Council on Homelessness and following the publication of a document entitled *A Plan, Not a Dream: How to End Homelessness in Ten Years* [xii] by the National Alliance to End Homelessness, there has been a major expansion in similar Ten-Year Plans in localities throughout the country. As of the end of 2008, 860 cities and counties had created 355 Ten-Year Plans.[xiii] Most of these local Ten-Year Plans call for substantial increases in permanent supported housing as a strategy to eliminate chronic homelessness.

In recent months, advocates have called on the Obama Administration to continue to expand investments in permanent supported housing for chronically homeless persons. A chapter on "Hard to House" persons from a recent policy paper prepared for HUD Secretary Shaun Donovan lists integrating housing and services to deliver permanent supported housing for

chronically homeless persons as one of its primary recommendations.[xiv] The paper recognizes the potential for interagency collaboration as a means to expand investment in permanent supported housing, and makes the observation that a partnership between HUD and HHS, including making Medicaid coverage more flexible, represents the greatest opportunity for collaboration.

Despite a growing preference for targeting chronically homeless persons with permanent supported housing, much remains to be done. From 2002 to 2007 an estimated 65,000 to 72,000 units of supported housing, representing about 50 percent of the current supply of supported housing units, were created in the United States.[xv] These units are welcome additions and undoubtedly are a large reason why the number of chronically homeless persons dropped by about 30 percent between 2005 and 2008. However, according to some observers, an additional 90,000 units of permanent supported housing are still needed to finally end chronic homelessness.[xvi] Given that roughly 30,000 units currently in development, an adequate level of investment would entail the creation of about 15,000 additional units annually for four years. Creating new permanent supported housing is neither a simple nor inexpensive process and will require collaboration between agencies as well as the efficient use of resources. What is more, creating new units of supported housing need not entail substantial new construction. Instead of building new units, most of the supported housing that is still needed can be provided in communities through their existing supply of housing with the assistance of Section 8 vouchers. There are compelling principles underpinning the concept of permanent supported housing as well as significant evidence of it being both an effective and fiscally sound strategy for reducing chronic homelessness. All of these factors point to the leveraging of resources from multiple

sources to expand the number permanent supported housing units as responsible, if not essential, policy.

Permanent Supported Housing: Program Models and Funding

The term "permanent supported housing" does not imply one specific program model, but rather a number of program types and housing arrangements. Nonetheless, permanent supported housing is broadly defined as subsidized housing matched with accompanying supportive services. Providers of permanent supported housing cover a broad swath ranging from public entities to private nonprofit agencies. Underlying the permanent supported housing approach is the determination that permanent housing, with the residential stability it provides, is essential to the success of clients in all dimensions of their lives. While housing may be treated separately from health, mental health treatment, educational or vocational needs, permanent housing is vital for stability, recovery and success in all these areas. In this sense, permanent supported housing programs stand in contrast to a residential "linear continuum model" which views substance abuse, mental health disorders or other serious difficulties as obstacles needing to be addressed in order to make a person "housing ready." Permanent supported housing programs, instead, stress that clients determine when and which services they access and views residential stability as crucial, even primary, in order that clients be able to benefit from treatment services. In fact, a foremost emphasis in permanent supported housing programs is helping persons become good tenants who can remain stably housed, as opposed to requiring *a priori* compliance with a treatment regime.

Programs falling under the permanent supported housing umbrella generally share a set of key elements. A recent HUD report identifies the key elements of permanent supported housing programs.[xvii] First, housing is affordable for those on SSI incomes (i.e., persons spend

no more than 30% of their incomes). Second, clients have choice and control over housing. Third, housing is permanent, which most often means that a lease agreement is in a client's name, and maintenance of housing is not contingent on participating in services. Fourth, housing is functionally separate from, though still linked to services. Fifth, supportive services are not delivered according to a set program but rather are flexible and tailored to the needs of individual clients who meet specified admission criteria, usually high need and high service utilization. Finally, integration of services, personal control, personal choice and autonomy are central principles for permanent supported housing.

The availability of flexible and as-needed support services, including preventative health care, is fundamental to the permanent supported housing model. The provision of these services is what permits a shift of costs from expensive, acute care services, such as inpatient hospitalizations and emergency department visits, to less expensive community-based services. There is much variation among programs in terms of the type and extent of services provided to tenants. This variation is partly a function of the varying characteristics, desires and needs of supported housing tenants and partly a function of the resources at the disposal of providers. Although not an exhaustive list, the services most commonly offered to tenants are: *Clinical case management* services that assist tenants to manage their health or mental health problems, encourage their use of necessary health care services, limit their substance use or prevent relapse, and develop social skills necessary for community integration. Many traditional case management services coordinate services, help link tenants with appropriate care systems and ensure that they receive and use government benefits and programs such as SSI for which they are eligible. Tenants may also receive *medication management assistance* and *budget counseling,* important for independent living. Many programs also provide *employment services,*

including vocational rehabilitation and workplace preparedness training and *educational programs*, such as GED courses. In addition, *legal services* and *transportation* to help tenants access medical and mental health care are common supportive services.

Permanent supported housing programs are funded primarily through either one of two HUD McKinney-Vento Homeless Assistance Programs: the Supportive Housing Program (SHP) or the Shelter Plus Care Program. Under the recently passed HEARTH Act, both the Supportive Housing Program and the Shelter Plus Care will be combined into one Continuum of Care program to streamline the funding process, and the currently mandated set asides for permanent housing will be preserved.

Permanent supported housing programs have experienced growth in recent years thanks in part to policy and actions on the Federal level; yet to some observers, permanent supported housing "remains a product without a system to produce it."[xviii] This sentiment stems in large part from the reality that supportive eservices, which are critical to the success of programs, are often funded on an *ad hoc* basis. Providers typically rely on a mix of Federal, state and local funding sources that may not have been designed to fund services specific to permanent supported housing programs and the chronically homeless individuals who do well in this type of housing. Provider attempts to piece together funding for services that match the needs of tenants may result in inefficiencies and redundancies. In fact, HUD funds many services in permanent supported housing programs that would be compatible with HHS block grant spending, entitlements, Medicaid reimbursable services, and/or existing HHS and VA homeless service programs. The current inefficiencies that exist within the funding structure for services in permanent supported housing underscore the importance of interagency collaboration.

Permanent Supported Housing Can End Chronic Homelessness

In A Cost Effective Manner

There is now widespread support for permanent supported housing as the preferred strategy for addressing chronic homelessness. This support has been earned because of the strong evidence base for the approach. Of particular importance are *three key research findings* that together suggest the feasibility and cost-effectiveness of ending chronic homelessness: first, chronically homeless persons constitute a *finite and aging population*; second, *permanent supported housing is effective* at promoting residential stability among this population[xix] [xx]; and third, the *cost of providing permanent supported housing can be partially or entirely offset by substantial reductions in the utilization of expensive acute care services* such as emergency department visits, inpatient medical or psychiatric hospitalizations, detoxification services, and shelter and jail stays. This critical information makes the economic case for how public payers can benefit from creating supported housing programs. Medicaid, the VA and other public payers of health services, by collaborating in providing the supportive services for specifically targeted, high need, high cost individuals, can reduce the overall costs and burden of this population by pairing services with the housing necessary to their medical stability. This section will review the rationale and evidence both for the permanent supported housing approach in general and specifically for the involvement of Medicaid, the VA and other public payers of health services in services provided at supported housing settings.

Ending Chronic Homelessness Is A Realistic Imperative

Eliminating chronic homelessness is both realistic and imperative. Realistic because there is evidence that chronically homeless persons are a *finite population* coming largely from a particular age cohort, which is not being replaced by a younger cohort. It is imperative because this *population will become medically frail* in the next 10 to 15 years, facing complex medical

regimens, which without supportive housing will require expensive and restrictive institutional or nursing home care settings as the only alternatives.[xxi]

Research on the prevalence and dynamics of homelessness indicates that on any given night in the United States there are about 124,000 chronically homeless individuals, comprising 19 percent of the overall homeless population.[xxii] This is a manageable number of persons, and given the appropriate resources and political will, it would be possible to give all of these individuals permanent housing.

Research suggests that the *age distribution of the population of homeless single adults* is skewed significantly towards those from the latter half of the baby boom generation, and who are not being replaced by the cohort behind them.[xxiii] In other words, due to demographic shifts, comparatively fewer middle-aged persons are now at risk of becoming chronically homeless. Thus, there is a real potential for sustained reductions in chronic homelessness, without replacement by a younger cohort, through the provision of permanent supported housing to currently homeless persons.

We must act quickly to end chronic homelessness in order to avoid a homeless crisis among older persons. In the next decade, as members of the baby boom cohort among the chronically homeless grow older, they face an increased risk of mortality and will experience more health problems and illnesses that require ongoing care.[xxiv] As members of this population age into their fifties, and with a life expectancy in the low 60s, they are likely to become medically frail. If they are not living in stable housing, with access to care, they are at risk to end up in nursing homes and other institutional settings, which is much more expensive than supported housing. Because nursing home care is eligible for Medicaid reimbursement, an increase in nursing home placements of chronically homeless persons stands to add to the burden

on Medicaid budgets. Legal challenges pertaining to the Olmstead decision may also challenge unnecessary restrictions on the liberty of persons with disabilities in nursing homes and other institutional settings (including adult homes).

Permanent Supported Housing Improves Residential Stability

There is strong evidence that permanent supported housing is an effective strategy for reducing chronic homelessness. A number of studies, most of which focus on persons with serious mental illness, have found permanent supported housing to be more successful than alternative approaches in terms of improving residential stability among chronically homeless persons.[xxv xxvi xxvii] Most evaluations have found housing retention rates of more than 80 percent of those placed in permanent supported housing. Moreover, tenants report satisfaction with their housing arrangements.

In the early 1990s, a series of demonstration projects sponsored by the National Institute of Mental Health (known as the Second Round McKinney Programs) tested the effectiveness of various housing arrangements for homeless adults with mental illness. Results from these projects showed that about 80 percent of persons placed in housing remained stably housed after two years.[xxviii] Other findings point to the effectiveness of permanent supported housing, especially in comparison to the linear continuum residential model. After 5 years, 88 percent of those enrolled in Pathways to Housing, a supported housing program in New York City, remained housed compared to only 47 percent of those in linear residential treatment programs for mentally ill homeless persons operated by a number of agencies and monitored by New York City's Human Resources Administration.[xxix] Another study tracked persons placed in three different types of supported housing and found that 75, 64, and 50 percent of the study sample remained continuously housed after one, two and five years, respectively. Using a randomized

design, another study found those in the experimental supported housing condition spent less time homeless and more time in stable housing relative to those in the control group who received services through a traditional linear treatment model.[xxx] [xxxi] Homeless persons with severe mental illness also have reported greater satisfaction with independent supported housing relative to congregate community residences.[xxxii] Moreover, findings demonstrating a lack of significant differences in substance use between clients in traditional treatment-first housing programs and those in supported housing,.[xxxiii] In summary, permanent supported housing is an effective method for getting chronically homeless persons off of the streets and out of shelters and into stable and satisfying housing arrangements, without negative treatment effects.

Permanent Supported Housing Can Generate Cost Savings

Permanent supported housing programs require investment. A housing subsidy can cost as much as $8,000 per year, and support service costs for chronically homeless persons with mental illness are generally in the range of $6,000 to $12,000 average annually (with variations in client costs from year to year). It has been essential to demonstrate the effectiveness of these high cost programs. Both academic and non-academic studies have demonstrated reductions in inpatient hospitalizations, emergency room visits and utilization of other expensive acute services subsequent to placement in permanent supported housing. *The primary implication of these studies is that the costs of supported housing for chronically homeless persons can be offset, either partially or totally, by acute care service reductions in this targeted population.* We believe this evidence provides compelling support for permanent supported housing as a preferred strategy. Most of the service reductions from supported housing occur in expensive medical services such as emergency department visits and inpatient hospitalizations, paid for by

HHS, states and the VA. This provides the further rationale for interagency collaboration to expand the availability of permanent supported housing.

A number of studies have shown substantial reductions in expensive health services utilization associated with placement in supported housing. A few have even specifically examined reductions in Medicaid reimbursed care services subsequent to housing placement. The results of these studies offer some indication on the extent to which Medicaid programs are likely to benefit from investments in permanent supported housing for chronically homeless persons. Table 1 offers a summary of studies that document reductions in health services associated with supported housing; the results of these studies are detailed below as well.

Table 1-Summary of Studies on Impact of Supported housing on Medicaid/Health Services Utilization and Costs

Study Location/Author	Study Description	Impact of Housing
Seattle[xxxiv]	Tracked acute service use of 95 homeless chronic public Inebriates placed in permanent supported housing	**In one year after entering housing:** -41% drop in Medicaid charges -19% drop in EMS paramedic interventions -42% fewer days in jail - Monthly cost offset of $2,449 per person
New York City[xxxv]	Used administrative data to track the acute care services use of nearly 5,000 homeless persons with severe mental illness prior and subsequent to housing placement	**In two years after entering housing:** -95% of housing costs offset by acute service reductions -89% of reductions due to declines in inpatient health expenditures -40% drop in Medicaid reimbursed inpatient days -$4.5 million drop in amount billed to Medicaid
Connecticut[xxxvi]	Evaluation of Connecticut Supported housing Demonstration Program that examined services use of 126 tenants who received Medicaid-covered services and stayed in housing for 3 years	**In three years after entering housing:** - 71% decrease in the average Medicaid reimbursement per tenant using medical inpatient Services
Multi-site: San Francisco, San Diego, New Orleans, Cleveland[xxxvii]	Experimental study tracking health and mental health services use, shelter and jail stays of 460 homeless veterans randomly assigned to supported housing, intensive case management only, or standard VA care conditions	Due to a cost offset, the net cost of the supported housing condition was about $2,000 per unit annually
San Diego[xxxviii]	Examined the mental health services utilization costs by tenants in a housing program in San Diego for persons with serious mental illness prior and subsequent to housing placement	**In two years after entering housing:** - 41% decline in per person cost of inpatient and emergency mental health services

San Francisco[xxxix]	Used administrative data to examine the impact of permanent supported housing on acute public health services by 236 homeless adults with mental illness, substance use disorder, and other disabilities	**In two years after entering housing:** -56% decrease in overall number of emergency department visits -Significant reduction in likelihood of being hospitalized -Significant decrease in average number of hospital admissions per person
Chicago (Sadowski et al., 2009)	Examined health services use of 407 homeless persons with a chronic medical condition randomly assigned to supported housing or usual care conditions	**In 18 months after entering housing:** -Compared with usual care group, permanent supported housing group had fewer hospital days, fewer emergency department visits and used half as many nursing home days
Denver[xl]	Tracked service utilization of 19 chronically homeless adults with disability two years before and after placement in supported housing	**In two years after entering housing:** -34% fewer ED visits -40% fewer inpatient visits -82% fewer detoxification visits -73% drop in ED costs -66% drop in inpatient costs -Average savings of $31,545 per person over 24 month period
Maine[xli]	Compared service utilization of 163 homeless persons with disabilities in rural Maine in the six months prior and six to twelve months subsequent to housing placement	**In six months to one year after entering housing:** -79% drop in cost of psychiatric hospitalizations -14% drop in ED -32% drop in ambulance transportation -4% drop in inpatient health care hospital costs -Annual cost savings per person of $1,348

An evaluation of a supported housing program for chronically homeless persons with severe alcohol problems further found that utilization of Medicaid funded health services declined by 41 percent in the one year following program entry.[xlii] In accounting for reductions in all acute services subsequent to housing placement, this study found that savings more than offset the cost of the housing intervention, yielding a net monthly savings of $2,449 per person. Another study examining the acute care services use of nearly 5,000 persons prior and subsequent to housing placement, found that 95 percent of supported housing costs were offset by acute service reductions, with 89 percent of the reductions attributable to declines in inpatient medical expenditures.[xliii] In fact, the same study found that the number of Medicaid reimbursed inpatient days declined by more than 40 percent in the two year period following housing placement, resulting in a corresponding $4.5 million drop in the amount billed to Medicaid. Yet another evaluation of a supported housing initiative for homeless persons in the State of Connecticut yields similar results in terms of the dynamics and costs of Medicaid reimbursed

health services utilization prior and subsequent to housing placement: the average Medicaid reimbursement for inpatient medical services declined by 71 percent following placement in housing.[xliv] All these studies underscore that there is a delimited, high need, high cost population who, if appropriately targeted, can not only benefit from supported housing but whose overall health care costs go down following housing placement.

When considering these studies, it is important to note that reductions in expensive inpatient health services subsequent to housing are often accompanied by increases in the cost of Medicaid outpatient, home health and other ongoing health services. This is a desirable result, as the provision of health services helps maintain supported housing tenants in the community without frequent, expensive inpatient hospitalizations. What is more, reductions in inpatient and emergency care have been found to be greater than increases in Medicaid funded outpatient services, resulting in a net positive cost offset from housing placement.

Other studies, while not necessarily looking specifically at Medicaid health expenses, have shown that permanent supported housing leads to substantial reductions in the utilization of expensive health care and other public services more generally.[xlv] [xlvi] [xlvii] [xlviii] Collectively, these studies offer strong evidence that Medicaid and other public health payers can benefit from investments in permanent supported housing.

One such study examined the mental health services costs associated with a housing program in San Diego for chronically homeless persons with serious mental illness.[xlix] The study found that the per person cost of inpatient and emergency mental health services declined by 41 percent subsequent to placement in housing. Reductions in these services as well as in mental health services provided in the criminal justice system, were enough to fully offset the increased case management and outpatient mental health services associated with program participation. A

study of supported housing programs in San Francisco also found that chronically homeless persons recorded fewer emergency department visits and inpatient admissions following housing placement.[l]

A recent study conducted in Chicago is innovative in its evaluation of the cost-effectiveness of housing interventions for chronically homeless persons. Using a randomized design, the study investigated the health and residential impact associated with providing supported housing to homeless persons with a chronic medical condition.[li] Compared to a control group who received standard care, the group placed in supported housing had fewer inpatient hospitalizations and fewer overall inpatient days during an 18-month follow up period. Researchers also found that the supported housing group used half as many nursing home days as the usual care control group.[lii] The final results of the cost analysis from this study have yet to be published, but preliminary results show that annual medical expenses for housed clients were significantly lower compared to the usual care group.[liii]

Other locally generated studies have yielded similar findings. For example, a cost-benefit analysis of a supported housing program for chronically homeless persons in Denver found cost reductions of 73 and 66 percent for emergency department and inpatient services, respectively, following housing placement.[liv] While most evaluations of supported housing programs focus on urban areas, a recent study considered service utilization reductions associated with a permanent supported housing program for chronically homeless persons in rural Maine.[lv] Like its urban counterparts, the Maine study found substantial reductions in emergency department visits, inpatient hospitalizations for physical health problems and the utilization of psychiatric inpatient hospital care among persons placed in supported housing. This study extends our understanding

of the effectiveness of supported housing for homeless persons in rural areas, a population that is traditionally difficult to serve.

Permanent supported housing can lead to substantial savings for Medicaid, the VA and other public payers of health services. However, other public care systems, such as the criminal justice or public shelter systems, also experience cost savings from permanent supported housing; in other words, placing chronically homeless persons in permanent supported housing can even generate further cost offsets outside of the health arena.

A study conducted in New York City used administrative data from seven public service systems to analyze utilization of public shelters, public and private hospitals, and correctional facilities in the two years prior and subsequent to placement in supported housing.[lvi] Persons placed in housing significantly reduced their utilization of shelters and spent less time incarcerated, creating substantial non-health cost offsets. Moreover, the study did not include additional public costs such as the courts and transportation to emergency departments, which had they been considered, would have further increased the non-health cost offsets resulting from supported housing.

A recent study in Seattle found that when combined with reductions in health care costs, decreases in the utilization of criminal justice, shelter, detoxification, and other services more than fully offset the cost of permanent supported housing for a group of chronically homeless persons with severe alcohol problems.[lvii] Collectively, the supported housing tenants reduced their service costs by more than $4 million in the year following placement, and per person cost offsets averaged $2,449 relative to a control group at six months subsequent to program entry. Similarly, a study conducted in Denver using a sample of chronically homeless persons with disabilities found a net cost savings of $2,238 per person over a two-year period.[lviii] Other

studies conducted by community-based entities throughout the country have found combined annual per person cost reductions for health and non-health services ranging from $5,266 to $43,045 subsequent to housing placement.[lix] Reliance on small and/or convenience samples and the lack of comparison groups limits the generalizability of the results of some of these local studies. Nonetheless, they offer real examples of communities that have benefitted from implementing permanent supported housing initiatives for some target populations of chronically homeless individuals.

The collective evidence from academic research as well as practice-based studies demonstrates that placing selected, heaviest service using, and therefore most costly, chronically homeless individuals in permanent housing can yield cost savings, as service reductions more than offset housing costs. The potential for cost savings are greatest when housing and services are appropriately targeted at a finite group. With this idea in mind, two points need to be emphasized. First, to the extent that cost neutrality is required, there must be a reliable mechanism to ensure that only those who are eligible and will benefit most from supported housing are placed in such programs. Second, it is of great importance to provide housing and services to persons in accordance with their needs. The most extensive packages of housing and services should only be offered to persons with the highest levels of service utilization and the greatest service needs.

Chronically homeless persons who have less extensive and lower cost use of acute services certainly need not be ignored, though there is less of an opportunity for substantial cost offsets in placing them in housing. Including them in permanent supported housing programs tailored to their needs can still lead to net savings or relative cost neutrality in the aggregate. Moreover, new service models, including critical time intervention (CTI), which is intensive but

time limited (thus less costly), have shown some important successes as the primary service components of supported housing programs.[lx] Likewise, there must be an "off ramp" from more intensive services over time as tenants stabilize, improve and thereby can be effectively served with clinic and other less expensive ambulatory treatment services . Like CTI, community programs can practice the gradual and proper stepping down of services to meet changing client needs with good outcomes and prudent fiscal management. These models may in fact prove to be more efficient and less costly than current models, thereby increasing the possibility for cost neutrality or even cost savings, even among persons who are chronically homeless but who are less costly service users.

Proposed Policy Objectives

Ending Homelessness Requires Interagency Collaboration, Not Just More Housing

Permanent supported housing requires more than just housing resources. While affordable housing is fundamental to the success of efforts to end homelessness, we cannot end homelessness simply by building more housing. Ending chronic homelessness requires that affordable housing be linked to flexible and mobile services that vary over time and location. In this regard, it is essential that Federal and state agencies as well as funding sources on all levels work together to deliver both housing and services to chronically homeless persons.

There is strong justification for an increased role for Medicaid, the VA and other public payers of health services in increasing the supply of permanent supported housing, particularly scatter site apartments funded with Section 8 vouchers . Public payers of health services, including HHS and VA programs, Medicaid in particular, may benefit the most from expanding the provision of permanent supported housing to chronically homeless persons. In the context recently passed federal health care reform legislation, the expansion of permanent supported

housing will be especially important to avoid potentially substantial increases in Medicaid costs associated with currently uninsured single adults. Moreover, as many of the services provided to tenants in supported housing programs are similar to services already eligible for Medicaid reimbursement or through other public providers and programs, increased interagency collaboration is essential for limiting inefficiencies and strengthening the funding for permanent supported housing. To that end, the following two policy objectives will establish a path to ensure that resources are used in an efficient and effective manner.

Two Primary Policy Objectives

First, the supply of permanent supported housing, especially scatter site apartments, should be expanded to meet the needs of a limited but very high cost chronically homeless populations, and lower cost alternatives, such as modest housing subsidies, should be made available to chronically homeless persons with less intensive service needs. Recent years have seen substantial investments in permanent supported housing, which has led to a 30 percent reduction in the number of chronically homeless person between 2005 and 2008. However, according to one estimate, after factoring in turnover rates in currently operating units, an additional 90,000 permanent supported housing units are needed.[lxi] A portion of these units are currently being developed, but a sustained investment of 15,000 new units per year for a four-year period is needed to help end chronic homelessness.[lxii]

It is important to stress that creating units of supported housing does not always require capital development projects; supported housing can be done without newly built housing. Using Section 8 vouchers to provide permanent supported housing in scattered site configurations takes advantage of the existing, community based housing stock to house chronically homeless persons through a process that is quicker, cheaper and creates fewer community issues than

building congregate alternatives. Wherever possible, efforts should be made to integrate individuals into existing units within communities. This practice is efficient and has proven to be successful. For persons whose clinical and self-care needs may be better met in congregate living situations, existing buildings can be renovated to accommodate multiple private units with space for program staff and operations. In summary, while more supported housing units are needed, providing a sufficient amount of supported housing does not always need to entail expansion of the physical stock of existing housing. Section 8 vouchers are essential to this approach, and it is feasible that existing buildings and units can be coupled with flexible, mental health, substance use and medical services to house specifically identified, high need, chronically homeless persons.

It is also important to note that chronically homeless persons do not constitute a homogenous population; thus, permanent supported housing with high intensity services may not be necessary to meet the needs of all chronically homeless persons. Persons with a serious mental illness, who are most likely to require permanent supported housing, comprise about 30 percent of the overall population of chronically homeless persons.[lxiii] On the other hand, almost two thirds of chronically homeless persons have a primary substance abuse disorder or other chronic health condition. Some persons with a substance abuse disorder or other chronic illness may be able to achieve housing stability with a modest housing subsidy and fewer on-site services. A New York City housing subsidy program for formerly homeless persons with HIV/AIDS may be an exemplar in this regard. Under this program, New Yorkers living with HIV/AIDS receive modest rental assistance to help subsidize the cost of private market apartments, and with no services provided on-site. The program has been extremely effective for the majority of New Yorkers with HIV/AIDS who are formerly homeless, allowing more than

20,000 persons to remain housed in the private market, and may be a model for meeting the housing needs of other groups.[lxiv]

One currently operating program provides a potential model for how HHS, the Department of Labor, the Department of Education and the Social Security Administration might develop plans to expand the stock of permanent supported housing by matching service dollars to housing being created by HUD. The Veterans Affairs Supported Housing (VASH) program, a joint effort between HUD and the VA, relies on Section 8 vouchers to provide access to affordable housing for veterans. The Vouchers are managed at the local level by the VA and matched with VA support services to create permanent supported housing. The VA should continue to expand the HUD-VASH program. Indeed, indications that pending legislation with resources to fund as many as 40,000 additional HUD-VASH program slots are quite encouraging. In brief, the HUD-VASH program is a model for interagency collaboration, and highlights the fact that the success of collaborative efforts rests on the ability of agencies to allow their resources and programs to be used in a more flexible manner.

HHS should take note of the HUD-VASH example and develop means by which Medicaid can more flexibly fund supportive services. Thus, the *second policy objective calls for greater and streamlined access to specific Medicaid funded services for providers of supported housing.*. In short, we propose a national change in Medicaid policy that would not only make supportive services in housing programs eligible for Medicaid reimbursement but also develops a customized solution to make these Medicaid resources easier to access for providers of permanent supported housing.

There is strong rationale for this policy change as Medicaid is likely to benefit from the associated reductions in service costs by chronically homeless persons. Moreover, HUD spends

approximately 46 percent of its resources on supportive services activities. Half of this funding is used for services such as substance abuse treatment, HIV/AIDS treatment, mental health counseling and other health services, that Medicaid and other agencies might fund or already fund. Shifting the funding of these services to Medicaid would allow HUD to commit more resources directly to housing assistance.

Tenants in supported housing will experience positive outcomes if they are provided with a flexible package of mental health, substance abuse and medical care services delivered under an individualized plan. Fashioning a payment mechanism similar to the existing Home and Community Based Services (HCBS) Waiver represents one possible method through which Medicaid could more flexibly fund such a package of individualized services for chronically homeless persons in supported housing programs. Home and Community Based Services Waivers, permitted under Section 1915 (c) of the Social Security Act allow states to offer home-based services to persons who would otherwise be institutionalized. A number of states have used HCBS Waivers to fund services with some success, particularly for services provided to persons with HIV/AIDS. In addition, HCBS Waiver can be used to provide services to older adults who would be placed in nursing homes, highlighting their potential effectiveness as a tool for financing supportive services for older chronically homeless persons.

A waiver program targeted at chronically homeless persons will require modifications to the existing HCBS Waiver guidelines. To begin with, providers may not meet the requirement in many states that providers of HCBS Waiver eligible services be licensed to do so. Moreover, HCBS Waivers require that states demonstrate that the cost of Medicaid reimbursed home or community services is no larger than the cost to Medicaid for institutional care. We can make the case for such cost neutrality regarding chronically homeless persons who make frequent use

of expensive institutions and services, including hospitals, as detailed above. We can also maintain that it is economically advantageous for Medicaid to offer states a waiver similar to the HCBS Waiver to fund home and community based services under individualized plans for a targeted population of chronically homeless persons that meets some certain threshold for cumulative amount of time spent in institutional settings including shelters, hospitals, and jails where substantial costs to HHS also accrue.

Any expanded role for Medicaid in funding supportive services, whether through a waiver program similar to the HCBS Waiver or otherwise, faces a number of structural barriers that must be addressed. Overcoming these obstacles can be achieved with budget neutrality if the population and programs are highly specified and admission controlled through gatekeeping, thus making costs associated with implementing solutions outweighed by the benefits of greater access to Medicaid resources for supportive services. Confronting potential implementation barriers, however, will require both increased flexibility of Medicaid benefits and leadership at the Federal level. Four barriers in particular merit further attention.

First, in many states and regions there are certain services currently offered by supported housing providers that are Medicaid reimbursable. On the other hand, there are other services that Medicaid currently does not cover, but are likely good fits to be reimbursed by Medicaid. In these instances, Medicaid could adjust its policy to make such services reimbursable.

A second impediment to using Medicaid for funding supportive services concerns the often insurmountable structural barrier that supported housing providers must confront in obtaining Medicaid reimbursement for services. Even when providers offer services that are Medicaid reimbursable, many do not seek reimbursement due to the immense administrative costs and challenges associated with receiving payment. Many providers do not have a history

of billing for Medicaid services or simply lack the knowledge, infrastructure and administrative capacity necessary to access Medicaid resources. One way to overcome this challenge would be to conduct trainings to educate supported housing providers in how to access Medicaid resources and obtain payment for services that are Medicaid reimbursable. The availability of ongoing national technical assistance to providers would be an important and necessary supplement to any initial trainings.

A third barrier pertains to the mismatch between Medicaid's fee for service billing model and the type of ongoing and flexible services offered by supported housing programs. What is more, many supported housing tenants decrease their utilization of supportive services over time. This is a desirable outcome as it points to the success of housing programs of promoting self-sufficiency. Nonetheless, in a fee for service model it means that providers may be providing services that tenants do not need in order to obtain revenue necessary to meet operational expenses. Therefore, introducing customized billing procedures for services provided as part of supported housing programs would be a pragmatic alternative. These customized procedures might include daily or monthly Medicaid allowances for identified services for clients who are eligible on the basis of high need, with continuing care payments when services are not needed at the same order of intensity. Such a streamlined billing model would be a better fit with the service model in supported housing programs and would maximize the effectiveness of any training programs and technical assistance offered to housing providers,

Finally, the great variation in the types of services currently offered by supported housing programs complicates any effort to implement a policy geared towards expanding the role of Medicaid in financing such services. It will be necessary to define a standardized set of services that would be eligible for reimbursement. Establishing a prescribed set of Medicaid reimbursable

services is an important task, yet it is one that falls beyond the scope of this paper. Instead, the decision regarding which services to include in a well-defined package should be undertaken through a process that weighs evidence from research, housing providers, policymakers, advocates, and takes into account the expressed needs and preferences of supported housing tenants themselves.

Conclusions

Innovative policies, informed by evidence, have led to expanded investments in permanent supported housing in the past decade. But more needs to be done to direct policy and programming to make supported housing available to a delimited population of high need homeless persons. Ending chronic homelessness can be accomplished in a cost-effective manner, especially if multiple agencies partner to fund both housing and defined support services, to their mutual benefit as well as to the benefit of recipients and communities. Closely integrating HUD and Medicaid resources to provide permanent supported housing will be a departure from current policy, but allowing Medicaid resources to be used more flexibly in funding support services and streamlining the process through which providers access Medicaid funds is consistent with the evidence of the value of supported housing. Given the implications of the passage of landmark health care reform legislation, the time could not be better for Federal leadership to take action in improving the lives chronically homeless individuals and more prudently managing the public purse.

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