THE HEALTH EQUITY PROJECT
Advancing Health & Economic Opportunities for All Communities

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BUILDING THE VALUE CASE: MEDICAID'S ROLE IN ADDRESSING SOCIAL DETERMINANTS OF HEALTH

HOUSING INSECURITY

As the nation emerges from the COVID-19 pandemic, states face budget challenges and struggle to meet increased demand for health, behavioral health, and human services. In January 2021, the Centers for Medicare & Medicaid Services (CMS) issued guidance to state Medicaid Directors designed to drive the adoption of strategies that address the social determinants of health (SDOH) in Medicaid and the Children's Health Insurance Program (CHIP) so states can improve beneficiary health outcomes, reduce health disparities, and lower overall costs.[1]

Third Horizon Strategies (THS) conducted an extensive literature review and worked with its data partners Pareto Intelligence and Algorex Health to perform quantitative data analyses (including health care claims data analysis and predictive data modeling to measure social risk) to assess the economic case for addressing SDOH through Medicaid benefit design. The research examined a range of determinants including housing instability, food insecurity, isolation and loneliness, non-emergency medical transportation, joblessness, and activities of daily living.

Based on that research, this brief discusses housing instability as an important SDOH and suggests strategies that Medicaid directors and other state administrators, policymakers, and market stakeholders can undertake to improve housing stability among Medicaid beneficiaries and Medicaid eligible populations.

In the context of a pandemic, housing instability takes on an additional level of importance. Per the Centers for Disease Control and Prevention (CDC), eviction moratoria can be an effective public health measure and help prevent the spread of COVID-19 or other communicable disease.[2] For example, a Duke University study found that local eviction moratoria reduced the number of COVID-19 cases by 3.8 percent and COVID-related deaths by 11 percent . Longer term approaches may include providing legal and community support to those at risk of eviction. Ensuring an adequate supply of affordable housing, providing housing services and supports, and shaping public and fiscal policy to address housing instability are all critical strategies to improve the health of Medicaid beneficiaries and other at-risk populations.

INTRODUCTION

Housing status is a key SDOH. The instability introduced to a person's life wrought by housing insecurity is significant and can be linked to a range of different physical and mental health outcomes that bear a cost to society. For example, housing instability and homelessness are correlated with higher rates of emergency department (ED) utilization and hospital admissions, may worsen chronic physical and behavioral health conditions, and lead to increased morbidity and mortality. Housing insecurity can also contribute to Medicaid churn, as transient beneficiaries may lose coverage during the redetermination process. This challenge is further exacerbated when the provider or managed care organization (MCO) supporting the beneficiary's care is unable to maintain communication.

Medicaid can be a valuable program to channel or organize resources that help individuals and families facing housing insecurity. Research shows that investing in housing can produce budget savings through reduced health care costs. Further, housing investments are linked to improved health outcomes, which carries a propensity to improve productivity and boost economic activity.

This paper summarizes findings from a literature review and data analysis that demonstrates the irrefutable link between housing instability and poor health outcomes, promising interventions for addressing housing needs, and the potential cost and economic impact that can be realized through thoughtful policy that addresses housing instability as an SDOH.

Definitions

The CDC defines "Social Determinants of Health" as "conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes."[3]

"Housing instability" is an umbrella term that encompasses a number of challenges, such as having trouble paying rent, overcrowding, moving frequently, co-habiting with relatives, or spending the bulk of household income on housing costs. Homelessness is an extreme form of housing instability.[4]

The phrase housing insecurity is often used interchangeably with housing instability.

LITERATURE REVIEW

THS analysts reviewed 29 studies that examined the linkages between housing instability and poor health outcomes, and the evidence base around interventions that address housing needs. They scored 52 percent of the studies as "highly relevant," meaning they were published in the last four years, appeared in peer-reviewed or otherwise objective publications, had a strong evidence-base, and were clearly linked to measurable outcomes.

Numerous studies found strong correlations between housing instability and poor health outcomes for both children and adults, with the most dire impacts being on individuals and families that experience homelessness. Notable examples include:

- → One study on homelessness and the health of young children found that children who were homeless both pre- and postnatally were at highest risk of post neonatal hospitalizations, fair or poor health, and developmental delays compared with children who did not experience homelessness.[5]
- → Regression modeling in one study found foreclosures are associated with a 1.2 percent increase in ED visits and hospitalizations, a 4.9–6.7 percent increase in preventable hospitalizations among the non-elderly, a 12.0–18.8 percent increase in ED visits or hospitalizations related to anxiety, and 38.5– 41.7 percent increase in ED visits or hospitalizations for suicide attempts.[6]
- → Another study found that foreclosure, homelessness, or being behind in rent are significant predictors of depression, anxiety, and harmful alcohol consumption.[7]

The literature review revealed promising programs and interventions to address housing instability. The findings focus on various metrics including cost savings, utilization (e.g., ED visits), and housing program retention. There is particularly strong evidence that providing supportive housing (e.g., housing assistance with case management and/or connections to other supportive services) can reduce ED visits, admissions, and inpatient stays and result in large decreases in health care costs. While few of these studies specifically examined the role of state Medicaid programs, it can be inferred that promoting such interventions would significantly benefit states and result in a measurable return on investment.

One prominent longitudinal study is the "Moving to Opportunity for Fair Housing (MTO)," a federal program funded by the Department of Housing and Urban Development (HUD).[8] MTO offered housing vouchers to more than 4,500 families living in high-poverty neighborhoods in Baltimore, Boston, Chicago, Los Angeles, and New York City. Families were randomized into three groups. The first group received federally subsidized rental assistance certificates or housing vouchers that they could use only in census tracts with poverty rates of less than 10 percent, coupled with supportive services to help in leasing a new unit. The second group received Section 8 group vouchers with no restrictions and no moving counseling. The third group received neither subsidy but continued to be eligible for project-based housing assistance and any other social programs and services to which they would otherwise have been entitled. Four years after enrollment, the individuals in either of the two types of intervention groups (vouchers-only or the vouchers and counseling group) had a lower prevalence of extreme obesity, a lower prevalence of diabetes, and fewer self-reported physical limitations than the third group who only received traditional project-based assistance.

The most prominent intervention to address chronic homelessness is a model of permanent supportive housing (PSH) and wrap-around case management services, coined "Housing First." Housing First posits that providing a low barrier entrance to PSH, as well as empowering tenants' rights and responsibilities, will eradicate homelessness and help participants experience a better quality of life. Numerous studies have proven the model's efficacy in housing stability, identifying a long-term housing retention rate of up to 98 percent compared to 20 percent retention in a traditional housing model.[9]

Aside from Housing First programs, health care systems have also formed partnerships with cities and social service organizations to provide wrap-around services and housing services for patients. Another strategy is the creation of "Flexible Housing Subsidy Pools" (FHSP), an emerging systems-level strategy to fund, locate, and secure housing for people experiencing homelessness in a more coordinated and streamlined way. The FHSP offers states a way of "pooling" resources from public and private entities to provide financial assistance for rents coupled with supportive services. Direct, patient impact outcomes for these interventions are not publicly available.

QUANTITATIVE REVIEW AND METHODOLOGY

THS, Pareto, and Algorex Health augmented the literature review findings by reviewing health care claims data to quantify the impact of housing instability on health care costs and utilization. The research team constructed two regression models to assess the correlation and impact of certain community housing metrics on zip-code level health care costs and utilization. Researchers also used commercial claims data from across the country to create composite representations of these variables, with most claims emanating from Medicare Advantage beneficiaries. They sourced housing variables through Metopio, a web-based data analytics platform that aggregates public and private data sources for social factors at different geographic levels.

RESEARCH FINDINGS

Housing Insecurity Effects on Claims Cost

For the dependent variable, the research team used a composite dollar amount for the total average claims cost at the zip code level across the country. The model included age, risk-score, and a binary variable of new membership as independent control variables. The primary variables of interest in testing for a meaningful correlation between cost and housing insecurity were the percentage of households in a community that are "severely rent burdened" and the community's "median gross rent." Both of these independent variables were statistically significant at the 10 percent confidence level.

The model revealed that a one percent increase in severe rent burden (SRB) for the community results in a $124.98 increase in average claims cost. Relatedly, a one dollar increase in median gross rent (measured in absolute dollars) resulted in an increase of $242.48 in average claims cost.

Housing Insecurity Effects on Utilization

Stable housing may be a necessary precursor to appropriate utilization of primary care and behavioral health services. Conversely, housing insecurity can lead to higher rates of preventable health care utilization in more costly settings, particularly, EDs or hospitals.

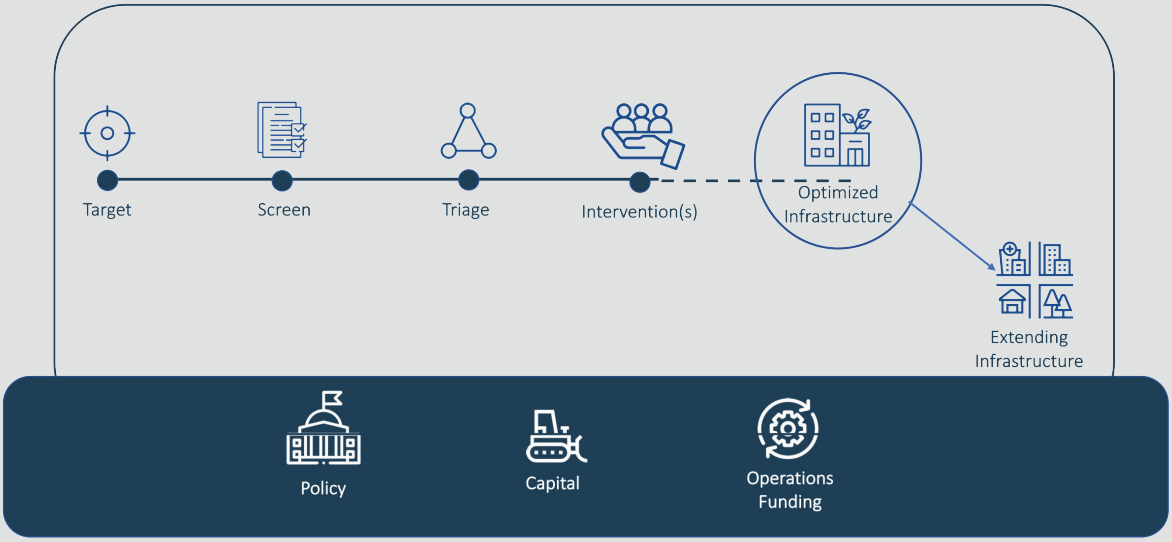
The research model found that for every one percent increase in housing transience (i.e., a resident that moves into current housing within the same county over the past year) there is a 1.3 percent increase in utilization of health care services. Transience in housing indicates a stressor to an individual or family that may be living with the uncertainty of what their future housing needs or challenges are. These financial or mental strains could well be serving to constrain the individual's or family's budget or otherwise catalyze the forgoing of important health-related services, decreasing preventive health care and primary care utilization. A key reason for this conclusion is a separate variable that indicates that for every one percent increase in owner occupied housing (the percentage of homeowners who occupy the domicile), there is a 1.67 percent increase in primary care utilization. The contrast between these two variables shows that stable housing is correlated with utilization of health care services in less costly settings.

Second, from a housing cost perspective, for every one dollar increase in median housing costs, there is a 1.5 percent decrease in utilization of health care services. The inference of this variable's coefficient is that constraints on household budgets cause home dwellers to forgo services that might otherwise be pursued were financial resources in greater abundance. Certainly, some of the forgone services may have been preventable and avoidable, establishing a favorable utilization impact for the community. However, the researchers suspect that a material proportion of such services may have been necessary, again curtailing the access of critical health-related resources for those who need them.

STRATEGIES STATES CAN USE TO ADDRESS HOUSING INSTABILITY

Exhibit 1 illustrates the guiding framework for these issue briefs, as noted in the **"Building the Value Case: Medicaid's Role in Addressing Social Determinants of Health"** introduction paper. The framework outlines a pathway of six activities and three foundational levers that govern the way these activities are funded, implemented, and operated. The structural approach to this model encourages states to problem-solve by examining the multi-faceted options at their disposal.

Exhibit 1: SDOH Strategy Framework



1. Target

For the purpose of this briefing, housing instability is stratified across three different levels:

- Insecure: The federal standard for affordable housing is housing that costs no more than one-third of a household's combined income. As rents or mortgages approach 50 percent of income they may become untenable and usually cause financial strain, which may complicate access to food, child care, preventive services, prescriptions, and transportation. Insecurity also can equate to elevated levels of stress which are correlated with mental health disorders such as anxiety, depression, or addiction.
- Transient: Transient is considered as having to move every few months or multiple times in a year for economic reasons. Higher eviction rates or severe rent burden are associated with transience that results in frequent intra-community or intra-regional relocations. Relocating, changing school districts, and disrupting continuity of care with providers can be detrimental to health outcomes and further exacerbate mental health or chronic conditions.
- Homelessness: Community members are homeless when they have no permanent housing and are living in shelters, tent cities, on the streets, or with family and friends. Homelessness is the most significant form of housing insecurity, driving preventable utilization and largely curtailing an individual's ability to contribute to their community.

Individuals and families facing housing insecurity are more likely to be Medicaid beneficiaries, uninsured, or underinsured. The most direct economic benefits can be found by isolating regions where there is both a higher level of Medicaid enrollment and one of the three tiers of housing insecurity. In these areas, interventions are likely to effectuate an impact on costs to the MCO or state.

As state leaders consider how to risk stratify housing needs, they may opt to take a geographic lens and identify neighborhoods at greatest risk, or they may take a population health management approach and screen and triage only Medicaid members. There are several data sources that can be used to identify neighborhoods with elevated levels of housing instability and diagnose the risk level for community members.

In all instances, lowering housing insecurity can correlate to improved health, lower costs, and greater economic productivity.

2. Screen

Once a state leader identifies a potential neighborhood or a population (e.g., Medicaid beneficiaries, Medicaid eligibles) for a housing insecurity intervention, they should conduct a screening.

While there is currently no standardized screening tool or questions used nationally, the literature review identified various models and tools that can facilitate screenings:

- Phone campaign to ask residents questions regarding housing insecurity
- Door-to-door campaign to ask residents standardized screening questions
- SDOH screening of Medicaid beneficiaries by care coordination entities and/or community health workers, navigators, or social workers in primary care or behavioral health clinics that includes questions related to housing insecurity
- Partnerships with community based organizations (CBOs), trusted organizations with deep knowledge about local resources and supports, and primary care providers (PCP) to routinely screen for housing insecurity using standardized screening questions

Importantly, the results of these screening questions should be accessible through a common registry, population health management system, clinical information interoperability, or reporting to a central authority in compliance with HIPAA regulations.

The literature also identified questions that accurately identified housing insecure community members. These questions and the process guiding inquiry should be standardized. Question samples are shown in Exhibit 2.

Exhibit 2: Screening Questions Linked to Accurate Identification and Stratification

North Carolina Department of Health and Human Services[10]	Accountable Health Communities[11]
1. Within the past 12 months, have you ever stayed: outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else's home (i.e., couch-surfing)? 2. Are you worried about losing your housing? 3. Within the past 12 months, have you been unable to get utilities (heat, electricity) when it was really needed?	1. What is your living situation today? o I have a steady place to live o I have a place to live today, but I am worried about losing it in the future o I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park) 2. Think about the place you live. Do you have problems with any of the following? CHOOSE ALL THAT APPLY o Pests such as bugs, ants, or mice o Mold o Lead paint or pipes o Lack of heat o Oven or stove not working o Smoke detectors missing or not working o Water leaks o None of the above

The screening process should include a workflow to directly facilitate referrals to a participating CBO or provider entity.

3. Triage and Care Coordination

States must follow up on housing screening with a systematized approach to triage and care coordination that connects Medicaid members with needed community resources. States can accomplish this by establishing Primary Care Case Management programs (PCCM), requiring MCOs to carry out these functions, and/or paying for intermediary organizations designated to engage with these community members. Such intermediaries can include:

Triaging Entities	Examples
Behavioral Health (BH) or Long-Term Services and Support (LTSS) Community Partners	Massachusetts' Community Partners Program[12]
Community Based Organizations (CBOs)	Oregon Coordinated Care Organizations[13]
Health Homes	State directed entities operating under Medicaid State Plan Amendment authorization[14]

The literature review indicated the importance of supporting community members with transitions through the process, employing dedicated care coordinators or navigators who can serve as a primary point of contact, connect community members with needed housing supports, and serve as an advocate through the process.

4. Interventions

There are two interventions that boast strong evidence of mitigating different levels of housing insecurity.

- Supportive housing: Housing assistance that is accompanied with case management, behavioral health services, and/or connections to other supportive services. This intervention is focused on community members that are housing insecure and/or transient. The Move to Opportunity program is a prominent example of this intervention.
- Permanent supportive housing: Programs designed to lower the barriers to contiguous, permanent housing with wrap-around case management systems. This intervention is focused on chronic homelessness. The Housing First program is a prominent example of this intervention.

Different permutations of these intervention categories abound. The most common principles are dedicated services that link housing needs to housing stock, case management services, access to other supportive services (to support related social determinant opportunities such as food insecurity, childcare, transportation, etc.), and access to physical or mental health-oriented services.

Successful housing interventions require a variety of agencies at the state and local level to work together. In 2019 the Medicaid Innovation Accelerator Program released a toolkit that describes best practices in partnerships between state Medicaid and housing agency partnerships. The toolkit points out that necessary partners will vary and may expand over time based on the state's goals and target population(s). Best practices described include development of common goals and objectives, actionable plans, and formalized data sharing agreements.[15]

5. Optimized Infrastructure

This category focuses on working within the constraints of the current infrastructure to facilitate interventions and provide ongoing services and support. Housing programs and housing units can be disjointed and fragmented, with efficiency gaps that fail to optimize existing capacity. Medicaid agencies and their housing intervention partners should actively collaborate with state housing agencies, local housing authorities, and non-profit housing organizations to create alignment and shared information to support interventions.

States can also optimize technology in numerous ways to address housing instability, such as:

- establishing digital apps that link to local housing information systems and can manage application requirements and coordinate logistical details, like what the Los Angeles Homeless Services Authority[16] and the Homelessness Resource App in Oakland, CA built by Code for American for the Community Housing Services Division,[17] have done
- funding technology incubators to source multiple coding companies or teams in the creation of a best-in-class app, awarding a cash prize to the best build
- fashioning other existing capacity management platforms (such as Open Beds or Patient Ping) to support a housing-oriented use case application
- utilizing apps to create text communication, AI-enabled supports, and information repositories that can assist would-be renters with information and assistance related to housing availability, eviction assistance, and landlord compliance reporting
- developing a registry (and/or leveraging an existing registry that aggregates data on individual/family level housing) that is interoperable with electronic health records (EHR) and other social support programs to create a single resource capable of better supporting individuals by having immediate access to history, socioeconomic conditions, and other criteria that would inform housing eligibility and determination

6. Extending Infrastructure

Communities often have insufficient infrastructure to address housing needs. Infrastructure gaps can be seen through an inadequate supply of housing units that match the underlying intervention or a lack of programs that provide supportive services.

Addressing housing stock is perhaps the most vexing of these issues because of the capital costs associated with refurbishing homes or new construction. However, there are a myriad of different creative and alternative capital financing options that policymakers and market stakeholders could pursue.

States can work in collaboration with cities to incentivize affordable housing development and optimize municipal zoning policies to promote investment and incentivize construction that fills empty lots or demolishes old and unsafe structures for replacement, leveraging Low Income Housing Tax Credits, Social Impact Bonds, and other financing tools.

7. Policy

In 2012, CMS provided a bulletin that addressed how states can comply with the Olmstead ruling, in which the U.S. Supreme Court determined unjustified institutionalization of people with disabilities was a violation of the Americans with Disabilities Act. CMS encouraged state Medicaid agencies to partner with state housing authorities to implement Section 811 Rental Assistance to support integrative programs for people with disabilities. CMS issued guidance in 2015 that clarified that state Medicaid agencies can offer individual housing transition services, tenancy sustaining services, and housing-related collaborative activities. In 2017, the agency issued guidance on lead abatement.[18]

In January 2021, CMS issued new guidance to state Medicaid agencies that describes "how states can leverage existing flexibilities under federal law to tackle adverse health outcomes that can be impacted by SDOH and supports states with designing programs, benefits, and services that can more effectively improve population health and reduce the cost of caring for our nation's most vulnerable and high-risk populations."[19]

The guidance does not establish new regulations but rather details existing federal authorities that states can use to address SDOH and provides examples of various state models. However, the guidance does represent a proactive and renewed effort on the part of the federal government to encourage states to maximize federal authorities. Specifically in regard to housing stability, the memo states "federal financial participation is generally available under certain federal authorities for housing-related supports and services that promote health and community integration, including home accessibility modifications, one-time community transition costs, and housing and tenancy supports, including pre-tenancy services and tenancy sustaining services."

States can use a variety of Medicaid policy levers to address housing insecurity and other SDOH. These mechanisms include home and community-based services (HCBS) under section 1915(c) waivers or the Medicaid state plan; targeted case management services; managed care under section 1915(b) waivers, the optional Community First Choice benefit and Money Follows the Person demonstration established by the ACA; section 1115 demonstration waivers; and Medicaid managed care contract language. While Medicaid cannot be used to pay directly for housing development or rental assistance, it can reimburse for supportive services that improve the probability of housing programs' success. For example, Medicaid can cover the costs of case management, tenancy support, behavioral health care, primary care, and other critical services.

In managed care states, state Medicaid programs can also promote housing stability by including housing requirements in their MCO contracts. According to the National Academy for State Health Policy (NAHSP), "by requiring health plans to indirectly invest in housing by hiring housing coordinators, partnering with existing housing agencies who are already immersed in the work, financing housing-related services, or by piloting new, creative solutions, states can take the lead in guiding Medicaid managed care plans' work."[20]

Several state Medicaid programs and/or their MCO partners have begun integrating supports for SDOH into their care management or care coordination strategies. According to research by Manatt Health, as of 2020, 27 states are screening for social determinants, 37 states are coordinating social services for beneficiaries, and 35 states are referring Medicaid members to social services. Housing instability should be included in these strategies.[21]

Kaiser Family Foundation's Annual Survey of Medicaid Directors found that the COVID-19 pandemic prompted over half of state Medicaid programs to expand programs to address SDOH.[22] Three-quarters of responding states reported initiatives in place or planned to address racial and ethnic disparities in health. Twenty-two states reported new or enhanced benefits in FY 2021, and 29 states are adding or enhancing benefits in FY 2022. Many states are focused on expanding behavioral health services, care for pregnant and postpartum women, dental benefits, and housing-related supports.[23]

Medicaid agencies can also convene or facilitate partnerships and data sharing between health care and human service providers that are necessary to improve coordination across programs and connect Medicaid members to services. For example, Louisiana's Medicaid agency uses its HCBS waiver to offer supportive housing services to reduce homelessness and unnecessary institutionalization among people with disabilities.[24]

Further, many states are utilizing 1115 waivers to implement demonstrations designed to test new service delivery and payment models. Through value-based and alternative payment models (APMs), states can create new opportunities for providers to gain flexibility to address SDOH. While traditional fee-for-service payment is tied to billable encounters, many APMs allow for providers to meet critical patient and community needs that may not qualify as "medically necessary" or billable services.

States can also leverage the new federally funded Housing and Services Resource Center to promote stronger linkages between housing and health care initiatives. A partnership between HHS and HUD, the Housing and Services Resource Center will implement a federally coordinated approach to providing resources, program guidance, training, and technical assistance to public housing authorities and housing providers; state Medicaid, disability, aging and behavioral health agencies; the aging and disability networks; homeless services organizations and networks; health care systems and providers; and tribal organizations.

The Housing and Services Resource Center also aims to facilitate state and local partnerships between housing and service systems and assist communities in leveraging new housing and service resources available through the American Rescue Plan or other federal resources.

8. Capital

Addressing housing insecurity should be a multi-stakeholder effort, given its impact on multiple systems such health care, public health, criminal justice, and education. Nationwide, there are cases where MCOs and health systems have made active capital investments because of the strategic necessity of lowering clinically inappropriate utilization (particularly in the emergency department), lowering costs, and/or achieving certain quality measures that promote bigger payments. Corporate partners – increasingly focused on diversity, inclusion, and equity (DEI) efforts – derive similar, albeit different benefits.

The government, or rather the taxpayer, is the primary beneficiary of housing investments because declining housing insecurity promotes lower costs for social programs (over time) and can boost economic productivity and development, expanding the region's tax base.

Opportunity Zones are one financing tool available to states. Created under the 2017 Tax Cuts and Jobs Act (TCJA), Opportunity Zones are economically distressed communities, defined by individual census tract, nominated by state governors, and certified by the U.S. Department of the Treasury. Under certain conditions, new investments in Opportunity Zones may be eligible for preferential tax treatment.[25]

Social impact investing is another unique and crucial area for investment. Facilitating equity-based investments that deliberately focus on promoting housing stock ownership is both a means of increasing stock and transferring wealth.

The Denver Social Impact Bond (SIB) program demonstrates that supportive housing gets homeless individuals off the streets and reduces the public costs of emergency services. According to evaluation done by the Urban Institute, after entering supportive housing, program participants maintained high housing stability rates, with 86 percent of the formerly homeless individuals remaining in stable housing after one year. At two years, 81 percent continued to be in stable housing and at three years 77 percent remained housed.[26]

While social impact bonds are currently the norm, states and municipalities can create social impact investment funds in neighborhoods to streamline the pathway to business ownership that achieves the dual objective of extended housing infrastructure. For example, a downtown Boston development is using complex financing to develop a building where every unit will rent at below-market rates. The development received state and federal tax credits and low-cost bonds, a break on city property taxes over the next 23 years, and a $10.5 million payment from Boston Properties and Delaware North. The complex also includes a 269-room hotel, whose profits will offset the development costs.[27]

Market participants are increasingly motivated to make these investments for community impact purposes. This includes both social service providers, hospitals, nonprofit housing organizations, and community finance investors (Housing Finance Authorities (HFA), Community Development Finance Authorities (CDFA), Community Loan Funds (CLFs), private philanthropy as well as traditional banks and investors). Medicaid Authorities should work to actively partner with these community groups, as well as state economic development entities, to maximize available financing for housing supports and services. States should partner with non-profit housing organizations and establish coalitions that raise, organize, and deploy unique combinations of capital.

Another strategy state Medicaid agencies can take is to encourage hospital systems to invest in affordable housing. To keep their tax-exempt status, nonprofit hospitals must engage in community needs assessments and contribute to improving their communities. A growing number of hospitals are investing in housing capital costs with the expectation that increasing available affordable housing for people who are homeless or at risk of homelessness and high-cost users of health care will help stabilize the person and reduce the need for high-cost hospital or health system use. For example, Denver Health partnered with Enterprise Community Investment to create affordable housing.[28]

9. Operations Funding

States can build financial incentives into their contracts with MCOs to ensure that Medicaid beneficiaries with housing and other SDOH needs are connected with community resources, such as including housing stability related measures in pay-for-performance programs. States can also encourage MCOs to invest in housing assistance programs to achieve Medical Loss Ratio (MLR) requirements. The 2017 CMS Managed Care Final Rules clarified that states can financially incentivize health plans to address these needs by allowing certain nonclinical services to be included as covered services when calculating MCO capitation rates and medical loss ratios.[29]

States can also test alternative payment methodologies that are designed to address SDOH including housing insecurity by pursuing 1115 waivers. Population-based payment models may offer more flexibility to providers to address whole person needs rather than focusing solely on traditionally billable, medically necessary services.

State Medicaid agencies can also incentivize MCOs and health care providers to partner with and/or contribute financial resources to local housing providers or to CBOs that address SDOHs.

In addition to Medicaid, states should look to leverage COVID-19 relief funds, behavioral health, and other state and federally provided resources that can support the implementation of supportive programming that can provide continuity of care for individuals as their housing need is stabilized.

CONCLUSION

Housing status is a key SDOH. Medicaid can be a valuable resource for helping individuals facing housing insecurity, and research shows that investing in housing can save states money by reducing overall health care costs and improving health outcomes. So, what should states do?

Key actions states can take include:

1. Utilize policy levers and evidence-based strategies to help address housing insecurity
2. Determine target population(s) using a risk stratification process based on either geographic and neighborhood level considerations or population health management risk criteria, or both.
3. Implement or refine their screening processes to ensure populations meeting the determined target criteria are appropriately identified.
4. Ensure housing insecure individuals and families gain access to needed resources by:
   a. bolstering triage and care coordination,
   b. supporting community members with transitions through the process,
   c. employing dedicated care coordinators or navigators who can serve as a primary point of contact,
   d. connecting community members with needed housing supports, and
   e. serving as an advocate through the process
5. Develop housing intervention strategies in partnership with other state agencies and local organizations
6. Optimize technology to support data sharing and population health strategies
7. Pursue creative and alternative capital financing options based on specific market needs and opportunities

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REFERENCES

1. Centers for Medicare & Medicaid Services (CMS). (2021). CMS Issues New Roadmap for States to Address the Social Determinants of Health to Improve Outcomes, Lower Costs, Support State Value-Based Care Strategies [Press release]. Retrieved from https://www.cms.gov/newsroom/press-releases/cms-issues-new-roadmap-states-address-social-determinants-health-improve-outcomes-lower-costs.
2. National Bureau of Economic Research (NBER). (2021). Housing Precarity & the COVID-19 Pandemic: Impacts of Utility Disconnection and Eviction Moratoria on Infections and Deaths Across US Counties. Retrieved from https://www.nber.org/papers/w28394.
3. Centers for Disease Control and Prevention (CDC). (2021). About Social Determinants of Health (SDOH). Retrieved from https://www.cdc.gov/socialdeterminants/about.html/.
4. Healthy People. (2020). Housing Instability. Retrieved from https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/housing-instability#1.
5. American Academy of Pediatrics (AAP). (2018). Timing and Duration of Pre- and Postnatal Homelessness and the Health of Young Children. Retrieved from https://publications.aap.org/pediatrics/article/142/4/e20174254/76765/Timing-and-Duration-of-Pre-and-Postnatal?autologincheck=redirected.
6. American Economic Association (AEA). (2015). Is There a Link between Foreclosure and Health?. Retrieved from https://www.aeaweb.org/articles?id=10.1257/pol.20120325.
7. National Poverty Center (NPC). (2012). Housing Instability and Health: Findings from the Michigan Recession and Recovery Study. Retrieved from http://www.npc.umich.edu/publications/policy_briefs/brief29/NPC%20Policy%20Brief%20-%2029.pdf.
8. U.S. Department of Housing and Urban Development (HUD). (1996). Moving to Opportunity for Fair Housing. Retrieved from https://www.hud.gov/programdescription/mto.
9. National Alliance to End Homelessness. (2016). Housing First. Retrieved from https://endhomelessness.org/resource/housing-first/.
10. North Carolina Department of Health and Human Services (NCDHHS). (2019). Screening Questions. Retrieved from https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/screening-questions.
11. Armstrong Brown, J., et al. (2020). Accountable Health Communities (ACH) Model Evaluation: First Evaluation Report. Retrieved from https://innovation.cms.gov/data-and-reports/2020/ahc-first-eval-rpt.
12. MassHealth. (2021). MassHealth Community Partners (CP) Program: Information for Providers. Retrieved from https://www.mass.gov/guides/masshealth-community-partners-cp-program-information-for-providers.
13. Oregon Health Authority. (2020). Addressing Housing Needs through Health-Related Services: A Guide for Oregon CCOs [PDF file]. Retrieved from https://www.oregon.gov/oha/HPA/dsi-tc/Documents/Health-Related-Services-Guide-Housing.pdf.
14. Centers for Medicare & Medicaid Services (CMS). (2020). Medicaid Health Homes: An Overview [PDF file]. Retrieved from https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/hh-overview-fact-sheet.pdf.
15. Medicaid Innovation Accelerator Program (IAP). (2019). Medicaid Innovation Accelerator Program State Medicaid-Housing Agency Partnerships Toolkit [PDF file]. Retrieved from https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/functional-areas/mhap-toolkit.pdf.

16. Smith, D. (2021). Finding housing for homeless people in L.A. County? Now there's an app for that. Retrieved from https://www.latimes.com/california/story/2021-05-18/finding-housing-for-the-homeless-in-l-a-county-now-theres-an-app-for-that.
17. Kendall, M. (2021). Oakland is building a new phone app for its homeless residents. Retrieved from https://www.mercurynews.com/2021/04/18/oakland-develops-app-to-connect-homeless-residents-with-services/.
18. Medicaid and CHIP Payment and Access Commission (MACPAC). (2018). Medicaid's Role in Housing. Retrieved from https://www.macpac.gov/wp-content/uploads/2018/10/Medicaid's-Role-in-Housing.pdf.
19. Levisohn, A. (2021). How States Improve Housing Stability through Medicaid Managed Care Contracts. Retrieved from https://www.nashp.org/how-states-improve-housing-stability-through-medicaid-managed-care-contracts/.
20. Centers for Medicare & Medicaid Services (CMS). (2021). CMS Issues New Roadmap for States to Address the Social Determinants of Health to Improve Outcomes, Lower Costs, Support State Value-Based Care Strategies [Press release]. Retrieved from https://www.cms.gov/newsroom/press-releases/cms-issues-new-roadmap-states-address-social-determinants-health-improve-outcomes-lower-costs.
21. Waddill, K. (2020). Lessons from Medicaid on Social Determinants of Health Innovation. Retrieved from https://healthpayerintelligence.com/news/lessons-from-medicaid-on-social-determinants-of-health-innovation.
22. Gifford, K., et al. (2021). States Respond to COVID-19 Challenges but Also Take Advantage of New Opportunities to Address Long-Standing Issues: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2021 and 2022. Retrieved from https://www.kff.org/medicaid/report/states-respond-to-covid-19-challenges-but-also-take-advantage-of-new-opportunities-to-address-long-standing-issues/.
23. Williams, E. (2021). Medicaid Enrollment & Spending Growth: FY 2021 & 2022. Retrieved from https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-spending-growth-fy-2021-2022/.
24. Katch, H. (2020). Medicaid Can Partner With Housing Providers and Others to Address Enrollees' Social Needs. Retrieved from https://www.cbpp.org/research/health/medicaid-can-partner-with-housing-providers-and-others-to-address-enrollees-social.
25. Internal Revenue Services (IRS). (2017). Opportunity Zones. Retrieved from https://www.irs.gov/credits-deductions/businesses/opportunity-zones.
26. Cunningham, M.K., et al. (2021). Breaking the Homelessness-Jail Cycle with Housing First: Results from the Denver Supportive Housing Social Impact Bond Initiative. Retrieved from https://www.urban.org/research/publication/breaking-homelessness-jail-cycle-housing-first-results-denver-supportive-housing-social-impact-bond-initiative.
27. Business Wire. (2018). Delaware North and Boston Properties Announce the Hub on Causeway Project Has Reached More Than 75 Percent Leased [Press release]. Retrieved from https://www.businesswire.com/news/home/20180731005899/en/Delaware-North-and-Boston-Properties-Announce-the-Hub-on-Causeway-Project-Has-Reached-More-Than-75-Percent-Leased.
28. Whitaker, K., Miller, J. (2021). Creating Affordable Homes with Health Services in Denver [Press release]. Retrieved from https://www.enterprisecommunity.org/news-releases/2021-03_denver-office-building-transform-affordable-homes-health-services/.
29. Centers for Medicare & Medicaid Services (CMS). (2017). The Use of New or Increased Pass-Through Payments in Medicaid Managed Care Delivery Systems: Final Rule by CMS. Retrieved from https://www.federalregister.gov/documents/2017/01/18/2017-00916/medicaid-program-the-use-of-new-or-increased-pass-through-payments-in-medicaid-managed-care-delivery/.