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Medicaid Demonstration Waivers with Housing Supports: An Interim Assessment

Frank J. Thompson, Ph.D.
Joel C. Cantor, Sc.D.
Jennifer Farnham, M.S.
Michael K. Gusmano, Ph.D.
Emmy Tiderington, Ph.D., M.S.W.

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Author Affiliations

Rutgers Center for State Health Policy

Frank J. Thompson, Ph.D., Board of Governors Distinguished Professor, Rutgers School of Public Affairs and Administration

Joel C. Cantor, Sc.D., Distinguished Professor & Director

Jennifer Farnham, M.S., Senior Research Analyst

Rutgers School of Public Health

Michael K. Gusmano, Ph.D., Associate Professor

Rutgers School of Social Work

Emmy Tiderington, Ph.D., M.S.W., Assistant Professor

Table of Contents

Acknowledgments

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Executive Summary

Some of the least healthy and most costly Medicaid enrollees are homeless or precariously housed. This is because homelessness and poor health are inextricably linked, with chronically homeless people having significantly shorter than average lifespans. Living on the streets often means living with serious health issues—including traumatic injuries, infections and infectious diseases, heat strokes or hypothermia, and illnesses related to substance abuse. At the same time, people with certain chronic health issues, such as those living with serious mental illness or substance use disorders, are at higher risk for becoming homeless. It is a vicious cycle made more so by the fact that homeless people often live without primary health care, necessitating the use of high-cost acute care for medical emergencies and serious illnesses.

Using federal 1115 waivers, some state Medicaid programs are experimenting with housing supports for enrollees who are homeless or precariously housed as a way both to improve their health and reduce their medical expenditures. This report—the first resulting from research examining the implementation of Medicaid housing support demonstrations in four early-adopter states—describes preliminary observations regarding program design in three states—California, Maryland, and Washington. A fourth state—Illinois—was not yet far enough along to be included here, but will be assessed in future reports.

While the waiver pilot programs are complex and their details differ significantly, two design options stand out: the use of local governments vs. a single third-party contractor to administer the pilot programs. Medicaid officials in California and Maryland opted to develop and disseminate highly detailed statewide requests for proposals (RFPs) for local governments, each requiring localities to meet five core criteria to be approved for pilot programs. In both states, the RFPs elicited positive responses, especially from governments in localities where homelessness and related housing problems are prevalent. Twenty-five localities in California and four in Maryland received state approval and are now implementing housing support demonstrations. In Washington, state officials contracted with a private, third-party program administrator. The winning bidder, Amerigroup, is now engaged in enrolling, training, and paying Medicaid provider organizations, which are delivering services to the target population.

While the available evidence suggests that the California, Maryland, and Washington demonstrations are off to a promising start, it remains an open question whether these initiatives will produce the desired results. The next phase of our research explicitly addresses this issue by focusing on the start-up implementation challenges of the housing support waivers and the strategies officials used to cope with them.

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Introduction

Official estimates indicate that on any given day about 550,000 people in the United States are homeless, with roughly two-thirds of them finding some respite in emergency shelters and the remainder fending for themselves in other ways (Henry et al. 2018, 10). These statistics do not reflect all those at significant risk of homelessness upon release from an institution (e.g., hospital, prison) or because of eviction.[1] Homelessness and poor health march in lockstep. Individuals with health problems, such as mental illness, are more likely to become homeless. In turn, being without stable housing increases the probability of morbidity and mortality (NASEM 2018, 24–25). As a 2018 report from the National Academies of Science, Engineering & Medicine finds, "individuals who experience homelessness are at higher risk for infectious diseases (including … HIV and hepatitis), serious traumatic injuries, drug overdoses, violence, death due to extreme heat or cold, and death due to chronic alcoholism." The report further underscores that persons experiencing chronic homelessness have markedly shorter life spans than the general population (by one estimate, an average life expectancy between 42 and 52 years) (NASEM 2018, 36). Homelessness not only undermines health, it also drives up health care costs through higher rates of emergency department and inpatient hospital utilization. It follows that some of the most costly Medicaid enrollees are homeless or precariously housed.

These health and expenditure concerns have kindled widespread interest in supportive housing programs for people experiencing homelessness as a means to advance a more cost-effective health care system. Housing support initiatives assume various forms, from those that help people locate stable housing and apply for rent subsidies to far more comprehensive approaches that combine housing, health care, and social services. Permanent supportive housing integrates rental assistance with combinations of pre-tenancy (e.g., search), tenancy sustaining (e.g., landlord dispute resolution), and health and social services or referrals, which, as the name implies, can be of indefinite duration (NASEM 2018). One permanent supportive housing model of growing interest to policymakers and practitioners is "housing first," which stresses finding residences for people who are homeless as the jumping-off point for

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[1] For an especially vivid ethnographic study of this cohort, see Desmond (2016).

subsequently improving their health and diminishing their need for hospital care.[2] When accompanied by intensive case management and coordinated care, advocates hypothesize that supportive housing will ultimately improve peoples' health outcomes while lowering their health care costs (Doran, Misa, and Shah 2013). An array of studies has probed this hypothesis with mixed results. Recent studies and systematic reviews of supportive housing and health care have demonstrated reduced hospital emergency department (ED) and inpatient use as well as less spending on this cohort (Gusmano, Rodwin, and Weisz 2018; Hunter et al. 2017; Ly and Latimer 2015; Wright et al. 2016). Research has also shown a connection between supportive housing and access to care, self-reported mental health outcomes, and overall well-being (Baxter et al. 2019; Benston 2015; Kyle and Dunn 2008; Rog et al. 2014). However, the National Academies noted important gaps in the research literature, concluding that there "is no substantial published evidence as yet to demonstrate that [permanent supportive housing] improves health outcomes or reduces health care costs." Nonetheless, the National Academies report calls for additional research on the question and affirms that "housing in general improves health." (NASEM 2018, 4)

Encouraged by findings such as these, Medicaid officials in several states have expressed interest in using various forms of housing supports to serve those who are homeless or precariously housed. Federal Medicaid law, however, places a substantial barrier in the path of these housing initiatives. While the program has long subsidized certain forms of housing for elderly adults and people with disabilities eligible for a "nursing home level of care" (e.g., in skilled nursing homes, intermediate care facilities, or small group homes), it cannot directly pay for housing for other cohorts of enrollees, including people who are chronically homeless. Within this legal parameter, the Centers for Medicare & Medicaid Service (CMS) has nonetheless issued an information bulletin in 2015 that encouraged states to consider housing support initiatives. The bulletin described the housing-related services Medicaid can subsidize not just for enrollees transitioning out of an institution to home and community-based services, but also for non-institutionalized individuals experiencing chronic homelessness. The information bulletin listed a range of pre-tenancy and tenancy-sustaining services that the federal Medicaid program would subsidize. It underscored that Section 1115 waivers might be valuable tools for states seeking to assist "individuals already in the community" rather than leaving a long-term care facility.[3]

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[2] The U.S. Department of Housing and Urban Development has over the last several years increasingly promoted the housing first approach in its grant programs. Among other things, the department has emphasized "persons experiencing homelessness should not be screened out or discouraged from participating in [housing] programs because they have poor credit history, or lack income or employment. Additionally people with addictions to alcohol or substances should not be required to cease active use before accessing housing and services." See Suchar and Miller (2016).

[3] The bulletin listed six other avenues for Medicaid housing supports embedded in Section 1905 and Section 1915 of Title XIX of the Social Security Act; these primarily targeted transitioning enrollees from institutions, such as nursing homes, to home and community-based services. See Wachino (2015).

Aware of CMS' posture, several states have obtained, or are planning to apply for, Medicaid Section 1115 waivers that feature housing supports. In developing and implementing these waivers, states face myriad issues of program design and implementation. Above all, they confront the challenge of integrating services from the housing and health care sectors (including specialists in physical health, mental health, and substance use disorders).

With grant support from the Robert Wood Johnson Foundation, our research team, based at the Rutgers Center for State Health Policy, is studying the start-up implementation challenges faced by four early-adopter states with housing support demonstration waivers approved by CMS: California, Illinois, Maryland, and Washington. Our study relies on two primary sources of evidence. First, we are exhaustively reviewing written materials—public documents from the four waiver states along with pertinent scholarly literature, think tank reports, and briefs produced by stakeholder groups. Second, we are in the midst of conducting 25-30 semi-structured, open-ended interviews, each averaging about an hour in length, with key stakeholders and experts in the four states. Ultimately, we aim to use the evidence gleaned from these sources to distill lessons about the start-up implementation challenges of the housing support demonstrations, and about strategies for surmounting them. We anticipate that these lessons will be valuable to federal authorities as well as states and localities interested in launching Medicaid housing initiatives. We expect to disseminate complete findings exploring the four states' *implementation* of housing support initiatives in early 2020.

In the meantime, this report offers preliminary observations from three of the states—California, Maryland, and Washington—about the *design* of these housing support demonstrations. We focus on certain aspects of the formal plans and protocols of the three states for achieving their objectives supplemented by initial insights from our interviews. (Because Illinois had not initiated waiver implementation as of early 2019 and aspects of its program design remain under development, we provide only general information about its waiver initiative.) State housing support designs contain many components and details, but two design features loom especially large—the degree to which they adopted a locally driven intergovernmental approach as distinct from a third-party private contractor model.[4] California and Maryland pursued the former. Medicaid officials in both states formulated fairly detailed requests for proposals (RFPs) from their local governments, which had to meet five core criteria to win approval. In response, 25 localities in California and four in Maryland have obtained state authorization to commence housing support pilots. In contrast, Medicaid officials in Washington issued an RFP to attract a private contractor to take charge of implementing the housing initiative. Ultimately, the state contracted with Amerigroup, a major health insurance and managed care provider, to implement the demonstration.

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[4] The research literature from public administration (or management) and policy implementation stresses that each of these designs presents its own set of potential advantages and disadvantages as a way to realize government objectives. See, for instance, Salamon (2002).

This report opens with an overview of key contextual and waiver characteristics in the four states. We then offer a preliminary assessment of the locally driven intergovernmental and the third-party contractor design models, respectively. A concluding section sets the stage for moving from design to the implementation challenges that we will subsequently examine.

Overview

While the four states with housing support waivers all had significant homeless populations, they differed in the degree to which homelessness prevailed. As Table 1 indicates, California and Washington had higher rates of homelessness per 10,000 population with a prevalence at a point in time that was roughly 75% greater than the national average of 17%. The data on California are particularly striking; nearly one-quarter of all homeless people in the United States reside within its boundaries. In contrast, Illinois and Maryland have homelessness rates below the national average.

Table 1: Homelessness in States with Medicaid Housing Support Waivers

Jurisdiction	Total Homeless	% of National Total	Homeless Per 10,000 Population
California	129,972	24%	33
Illinois	10,643	2%	8
Maryland	7,144	1%	12
Washington	22,394	4%	30
United States	552,830	100%	17

Source: *The 2018 Annual Homeless Assessment Report (AHAR) to Congress* (Washington, DC: U.S. Department of Housing and Urban Development, 2018).

Table 2 reviews key waiver characteristics in the four states. As the table indicates, California led the way in obtaining CMS approval for a five-year demonstration, followed by Maryland and Washington a year later. Illinois is the most recent, obtaining CMS authorization in 2018 for a waiver that will end in 2023. With some variations on the theme, the waivers target Medicaid enrollees with some combination of the following characteristics:
- people who are homeless, or those at risk for homelessness while transitioning out of hospitals, mental health facilities, nursing homes, jails, or other institutions;
- people who are precariously housed and at risk of needing institutional placement;
- people experiencing or at risk of homelessness with repeated instances of avoidable ED and hospital use; and
- people experiencing or at risk of homelessness with two or more chronic conditions and behavioral health problems.

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Table 2: Selected Characteristics of Medicaid Housing Support Waivers

Name	Brief Description	Target Population	Period of Waiver Approval
California: Whole Person Care Pilot	Local governments (mostly counties) can apply to address the housing needs of Medi-Cal enrollees who are high users of multiple systems; can offer pre-tenancy and tenancy support services; intensive case management to coordinate service delivery; also permits county housing pools to directly subsidize medically necessary services.	Homeless people or those transitioning from institutions (e.g., hospitals, mental health facilities nursing homes, jails) at risk of being homeless; targeting criteria also include repeated instances of avoidable ED use, hospital admissions, and nursing home placements; those with two or more chronic conditions and behavioral health problems.	2016–2020
Illinois: Behavioral Health Transformation Demonstration	The state plans to initiate and support 10 pilots in different geographic areas; pilots to provide tenancy case management and support services; intensive case management to coordinate services.	Similar to California with special attention to those at risk of homelessness at their time of release from an institution for mental diseases; those at risk of institutional placement.	2018–2023
Maryland: Community Integration Service Pilot	State gives localities opportunity to apply for funding to support pilots; can offer pre-tenancy and tenancy-sustaining support services; intensive case management to coordinate services.	Similar to California, especially those at risk of homelessness upon release from an institution or at imminent risk of institutional placement.	2017–2021
Washington: Foundational Community Supports Program	State contracts with third-party administrator to enroll target population and handle payment to providers who facilitate pre-tenancy and tenancy-sustaining services; intensive case management to coordinate services.	Those with behavioral health problems and limited ability to perform multiple activities of daily living; people with complex, continuing physical health needs; homelessness.	2017–2021

The brief descriptions in Table 2 highlight two major kinds of housing supports envisioned by all the waivers—those useful in obtaining housing and those helpful in keeping it. Pre-tenancy support includes such activities as locating housing, helping with the application process, and assisting with one-time moving expenses. Tenancy-sustaining services incorporate such activities as coaching enrollees on how to be a good tenant, financial counseling, anger management, and mediating tenant-landlord relations. Moreover, all of the waivers recognize the need for intensive case management to help integrate the services delivered by housing specialists with those of health care providers attending to the physical and behavioral health needs of enrollees. The brief description also captures the core design difference discussed above. California and Maryland feature a locally driven intergovernmental model where counties and cities play a lead role in forging provider networks and shaping the waivers. In contrast, Washington relies on a third-party administrator design where the state has contracted with Amerigroup to spearhead implementation. At this point, Illinois Medicaid officials appear committed to initiating 10 housing support pilots, but their *modus operandi* is not yet clear.

Locally Driven Intergovernmental Design: California and Maryland

Among the four states, California and Maryland stand out in terms of the degree to which they rely on local governments to design and implement the housing support waivers. In this section, we compare the two states in terms of: (1) state expectations of local applicants as embedded in their RFPs, (2) the local government response to the RFPs, and (3) state efforts to diffuse information and effective practices by establishing learning collaboratives.

State Expectations and Local Proposals

Both California and Maryland issued RFPs that set forth parameters for localities that wished to participate in the housing demonstrations (CDHCS 2016; MDH 2017). While the expectations of the two states differed somewhat, both RFPs stressed the need for local applicants to document how they would perform five core activities. We discuss each of these activities below and, drawing primarily on California,[5] provide examples of how various local governments responded.

First, both states expected local governments to forge a substantial network of diverse providers to implement the housing support waiver. This focus reflected the recognition that the demonstrations would need to surmount the functional silos that permeate health care, housing, and related sectors. Organizations and professional cohorts not used to working with one

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[5] The greater attention devoted to California stems from two factors. First, the state had the largest housing support program, which had been in operation the longest. Second, state officials promoted transparency by posting all pilot applications online. Copies of the approved Whole Person Care Pilot Applications can be found at http://www.dhcs.ca.gov/services/Pages/WholePersonCarePilotApplications.aspx.

another would need to cooperate and coordinate their efforts if the local projects were to succeed. Success depended not only on fostering productive networks[6] that included health care and housing providers; within the health care sector itself, greater integration of physical health, mental health, and substance use disorder providers would be important. Hence, state Medicaid officials expected local applicants to obtain signed commitments from a diverse group of providers.

Local governments in both states went to considerable lengths to create these diverse networks. The initial California RFP, for instance, called for applicants to designate a lead entity, at least one Medicaid managed care organization, a minimum of two community-based partners, and public agencies delivering health services, behavioral health treatment, and, where applicable, housing.[7] Approved pilots readily met and often exceeded this standard. For example, rural Shasta County near the northern border of the state listed 13 formal participants, while highly populous Los Angeles County, with some of the most pressing problems of homelessness, listed 30. Alameda County (which is in the East Bay, encompassing Berkeley and Oakland) illuminates the spectrum of providers in these networks. The county lists 21 local entities that in various roles would serve the Whole Person Care demonstration. These included:

- nine county agencies engaged in such tasks as medical care, behavioral health interventions, social services, information technology, and probation;
- three human services departments from Berkeley, Fremont, and Oakland city governments;
- three Medicaid managed care organizations; and
- six nonprofit community partners engaged in providing housing support (e.g., the East Oakland Community Project) or health care (e.g., Sutter Health Alta Bates Summit Medical Center).

Second, the California and Maryland RFPs stressed the need for localities to describe the magnitude of the problem and the population to be targeted for services. The RFPs probed how localities would recruit, enroll, and prioritize applicants as well as estimate numbers of participants. Local officials went to considerable lengths to respond to these and related requests for information. Los Angeles County, for instance, devoted nearly 30 single-space pages to this sphere of activity, noting that tens of thousands of people in its jurisdiction were homeless and identifying six major target groups for housing services. These included those considered high risk based on some combination of chronic homelessness, physical or mental disability, two or more chronic conditions, and recent or recurrent acute care utilization. Other targeted populations included people identified as "justice-involved high-risk," who were about to leave

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[6] For a general overview of network governance, see Agranoff (2007).
[7] Though the vast majority of Whole Person Care Pilots feature housing supports, it was possible for an applicant to stress alternative services.

prison or some other criminal justice institution; and "high-risk expectant mothers" who may be homeless, soon-to-be-released from incarceration, or suffering from various health problems.

Third, the RFPs from the two states asked the local governments to describe the services they would provide and how they would coordinate them, with special attention to the role of data sharing. The data requirement flowed from the view that the integration of diverse services depended on the establishment of a robust information system that incorporated both health care and social determinants data. For instance, the approved pilot application from San Mateo County (just south of San Francisco) pledged to develop a "completely integrated Health Information Exchange" (SMCHS 2016, 33), which would meld client data on housing and other social services with their health care records. San Mateo officials envisioned that this initiative would lead to the creation of an "Enterprise Electronic Health Record Platform" that would foster "more equality between social and patient-generated health data and the more traditional healthcare information gathered in an office or examination room" (SMCHS 2016, 35). Among other things, officials anticipated that the information system would allow them to predict which patients were more likely to become high utilizers of emergency departments, allowing them to intervene earlier to provide services. San Mateo officials also stressed the importance of case managers in connecting high ED utilizers with shelters, transportation, and housing.

Fourth, the two states expected local applicants to establish a performance measurement and management system. They required applicants to report on performance indicators state officials generated, to identify additional metrics, and to specify how they would gather valid and timely data to monitor progress. Maryland imposed somewhat fewer performance metrics on the local pilots than California. Officials in that state required all local governments to use five performance indicators. Three dealt with emergency department, hospital inpatient, and other institutional use by the targeted Medicaid enrollees. The two other mandated metrics probed the success of the pilot in promptly providing stable housing to clients and the satisfaction of the target population with the initiative. The state allowed local pilots to propose two additional measures, or to indicate their willingness to work with the state in identifying other pertinent indicators. In turn, California divided metrics into universal and variant categories. Like Maryland, the state's universal metrics included emergency department and inpatient hospital use by the targeted beneficiaries. They also incorporated two indicators of health care treatment—follow-up for enrollees hospitalized for mental illness, and engagement in treatment for those with substance use disorders. The final three universal indicators targeted administrative matters. For instance, one focused on the proportion of participating beneficiaries with a comprehensive care plan accessible to the entire provider team within 30 days of enrollment in Whole Person Care.[8] California officials then asked each locality to come up with at least four variant metrics unique to their pilots. These variant indicators needed to include at least one administrative process

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[8] Other administrative measures included documents demonstrating the establishment of care coordination, case management, and policies and procedures governing referrals as well as data and information.

measure, one standard health outcome metric, and a housing-specific indicator in the case of pilots emphasizing that function.

The California cases provide some sense of how local governments responded to performance indicator requirements. For instance, consistent with the RFP, the City of Sacramento promised to track performance on 12 metrics. On four of the universal metrics (ED visits, hospital inpatient stays, follow-up after hospitalization for mental illness, initiation of treatment for substance use disorders), the city pledged to establish a baseline during the first two years of operation. In year three, it promised a five percent improvement on the measures, rising to 10% in year four, and 15% in year five. The Sacramento pilot applied a similar standard of improvement to four of its five variant measures, specifically:

- a reduction of 30-day all-cause readmission rates to hospitals;
- an increase in the number of homeless participants placed in permanent housing within three months of enrollment;
- an increase in the number of enrollees referred to housing services who receive them; and
- Likert scale scores of pilot participants responding to a health status survey.

A fifth indicator gauged the number of meetings held for stakeholders to discuss Whole Person Care issues.

Finally, the two RFPs required local government applicants to address the financial dimensions of their proposed pilots—how they would obtain the local contribution, the overall budget, their approach to paying providers, and related matters. Of pivotal importance, both states required localities to make intergovernmental transfers (IGTs) of funds from their own coffers to the state. The state would them commit these monies to the Medicaid program to support health and related services embedded in the local housing support initiatives. This commitment of IGT funds would in turn leverage matching dollars from the federal Medicaid program. Hence, the local pilots had a chance to at least double the IGT funds they had submitted to support Medicaid covered services in their demonstrations. The RFPs also stressed the need for local applicants to specify where they would get the "non-federal share" of funding for their projects. These funds would cover expenses not allowable under Medicaid, such as for housing.

The need to fund the Medicaid IGT upfront kindled some concern among Maryland local officials. In contrast, many California counties had prior experience with IGTs and local officials tended to treat the funding mechanism more like business as usual. For instance, Shasta County proposed a financing structure where three of its cities, Anderson, Redding, and Shasta Lake, would transfer funds to the county to help support the IGT. These cities would also augment county funds for the non-federal share. The Shasta pilot proposal also identified the county housing authority as a key source of non-Medicaid dollars.

The RFPs from both Maryland and California provided a scoring system for evaluating proposals, which assigned different weights to the five main categories discussed above. While

generally similar, the two states varied somewhat in their scoring orientation. Specifically, California assigned twice as much weight to performance measurement and management as Maryland did. In turn, Maryland assigned 30% of the overall score to the financial dimension of the proposal, while California accorded less than 10%.

Local Government Participation

The efficacy of the locally driven intergovernmental design in no small measure depends on the degree to which local governments choose to participate, and can develop proposals that state officials will approve. Both California and Maryland had positive experiences in this regard. Participation of local governments was strong in California, a state with one of the highest homeless rates in the country. Twenty-three counties, one small-county collaborative (consisting of three localities), and the City of Sacramento established pilots. This meant that nearly half of all California counties had Whole Person Care initiatives transpiring within their borders. Under the terms of the Medicaid waiver, a local government could establish an acceptable Whole Person Care pilot without a housing component. But nearly all the approved pilots (23, or 92%) declared that supportive housing would be among their concerns (Pagel, Schwartz, and Ryan 2018, 2).

Moreover, a review of the pilot applications indicates that 22 of the 25 localities selected at least one housing metric as a performance indicator. Two counties (Alameda and San Francisco) opted for three housing measures. Alameda County, for instance, sought to track progress in terms of new housing placements for homeless people, the percent of the target population in less restrictive housing, and the proportion in housing after six months. Seven other localities (including Los Angeles County) chose two housing indicators. Only Contra Costa, Kings, and San Bernardino counties submitted no performance metrics related to housing. To further capture the salience of housing to the Whole Person Care pilots, we analyzed references to housing in their annual reports for 2017. A little more than half the pilots (14) made at least 10 references to housing activities with the remainder in single digits. Six counties had at least 30 housing-related citations in their annual reports; they were in order of magnitude: Alameda (82 mentions), Napa, Sacramento, Monterey, Shasta, and San Mateo (34 mentions).

Enrollments in the Whole Person Care pilots provide yet one more indicator of local commitment to the Medicaid demonstration. To be sure, enrollees do not necessarily receive housing supports. Still, Whole Person Care enrollment is a prerequisite for obtaining housing services under the demonstration. Total unduplicated, cumulative enrollments in Whole Person Care amounted to over 85,000 as of September 2018. The seven counties with enrollments of at least 1,000, which had also opted for housing performance metrics, were in order of magnitude: Los Angeles (25,488), San Francisco, Orange, Alameda, San Mateo, and Santa Clara (2,989). While some counties below 1,000 enrollees had yet to get their pilots off the ground, local government participation in the Medicaid demonstration is on the whole considerable.

The participating localities all had significant problems of homelessness. Los Angeles County had 55,000 homeless people while much less populous San Francisco had nearly 7,000,and Alameda over 5,600 (a nearly 40% increase since 2015) (Brown et al. 2018, 2; CSA 2018). In turn, Sacramento and San Mateo counties had some 3,700 and 1,300 homeless respectively, with both experiencing significant increases between 2015 and 2017 (Baiocchi et al. 2017, 3; SMCHSACH 2017, 6). Nor were problems of homelessness confined to more urban localities. With fewer than 180,000 residents, Shasta County still had approximately 700 homeless persons. The fires that swept through the county in 2018 threatened to increase this number.

Maryland Medicaid officials also succeeded in eliciting significant local government participation in their Assistance in Community Integration Services (ACIS) initiative. While Maryland's per capita homeless rate is below the national average, many local officials viewed housing for low-income people as a pressing problem in their jurisdictions. In the first round of applications, Medicaid administrators approved pilot proposals from Baltimore City as well as Cecil and Montgomery Counties. A second round of applications added Prince George's County to the roster of participating localities. While less than 20% of Maryland's 24 counties had active ACIS initiatives, the four participating jurisdictions were home to nearly half of the state's total population. Only Cecil County in the northern part of the state was more rural with a population of just over 100,000.

Among the participating localities, Baltimore City looms especially large in importance. With a little over 10% of the state's population, it has close to 2,700 homeless people, nearly 40% of Maryland's total measured at a point in time. While accounting for much smaller percentages of the state's homeless population than Baltimore City, Montgomery and Prince George's respectively rank third and fourth among Maryland counties on this metric. About nine percent of the state's homeless population is in Montgomery (where over 17% of all Maryland residents live) and seven percent in Prince George's (where 15% of the state's population dwells).[9] Thus, with the exception of Cecil, counties with more homeless people were more likely to participate in the Medicaid demonstration. Maryland Medicaid officials anticipated that the four pilots would enable them to serve 300 individuals annually. Optimistic about the potential to reach additional homeless and precariously housed individuals, Maryland Medicaid officials filed a request with CMS to double this number by January 2019.

Learning from Local Pilot Variation

The local pilots in California and Maryland vary considerably in their designs, strategies, and procedures. These and related variations provide an important opportunity for learning, which California and Maryland have tried to foster through learning collaboratives. Local officials in

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[9] Baltimore County, as distinct from the city, ranks second; see MICH (2017, 9, 13).

both states meet periodically to share insights and help disseminate best practices. For instance, a California conference in March 2018 focused on Whole Person Care practices being pursued in Santa Cruz and Solano Counties. Participants discussed how they envisioned learning from the Whole Person Care initiative and how they could enhance access to data useful for treatment decisions and for addressing programmatic issues. Maryland officials also hold regular meetings to discuss common challenges. One topic centered on how to find, communicate with, and keep track of people identified as eligible for homeless support services.

Third-Party Administrator Design: Washington

Washington, where an estimated 22,400 people experience homelessness on a given day (see Table 1), has the fifth highest prevalence of homelessness among states, trailing only much more populous California, New York, Texas, and Florida. Many areas of the state have very limited numbers of emergency shelters and publicly subsidized housing. In forging a Medicaid demonstration to help cope with this problem, state officials opted for a third-party administrator design. They issued a formal RFP to award a contract to a business or private nonprofit organization to implement the state's Foundational Community Supports (FCS) initiative, which seeks to provide housing and employment services to certain Medicaid enrollees. The state created FCS as part of a larger health system reform effort, which involved a reorganization primarily affecting two state agencies—the Health Care Authority (which runs Medicaid) and the Division of Behavioral Health and Recovery. The revamping also meant that Medicaid managed care organizations (MCOs) would for the first time take on behavioral health services, which had previously been carved out of their state contracts. Rather than deal with the complexities that followed in the wake of these organizational and program changes, as well as face the challenge of managing multiple contracts, state officials opted to turn implementation over to one primary contractor.

To this end, the Health Care Authority issued an RFP in late March 2017. The RFP indicated that the successful bidder would administer $200 million over the four-year term of the contract while serving an average monthly caseload of 7,500 individuals statewide. The RFP specified several FCS objectives that the successful bidder would have to promote (WSHCA 2017, 5). Above all, the third-party administrator would need to "deliver supportive housing and … employment benefits to eligible Medicaid individuals … through contracted networks." To that end, they would be expected to "build and maintain a statewide provider network and community supports for each benefit." Further, the successful bidder would have to "demonstrate that the provision of these benefits to individuals with complex health needs improves health outcomes and reduces dependence on more intensive service settings." State officials also expected that the contractor would partner with the state's five Medicaid MCOs. In fact a major requirement for

the contractor would be "to transition the administrative functions of the program to a sustainable model" aligned with these MCOs.

The RFP mandated that the successful bidder should be able to access the state's system for determining Medicaid eligibility. It also clarified that the contractor would have to provide encounter data for all services delivered under FCS using the standard reporting format developed by the Health Care Authority. State officials acknowledged that they would be modifying this format to accommodate the relatively unique supportive services of some FCS providers. The successful bidder would "also be required to maintain a system capable of adjudicating and paying claims." (WSHCA 2017, 5)

The RFP clarified that "supportive housing" encompassed two sets of services. One set focused on a "one-time community transition" to assist individuals in moving from an institution to a community setting, or to help those "at imminent risk of institutionalization" to remain in their homes. The second set stressed "community support services" aimed at providing ongoing assistance to help eligible individuals "obtain and maintain stable housing." (WSHCA 2017, 6) This latter cohort would include people experiencing chronic homelessness.

The RFP also alerted bidders to performance reporting requirements and the partnerships they would need to forge. The winning bidder would need to develop and maintain a "data dashboard" that would monitor service usage and other "outcomes to be identified as the program ramps up." (WSHCA 2017, 7) They would have to report progress on such indicators as the numbers receiving services, the numbers housed, eligibility determinations made, those on wait lists, and grievances filed by individuals. State officials anticipated that the contractor would submit monthly reports on these and other indicators. The RFP also underscored the need for the contractor to develop partnerships built on data sharing and other forms of collaboration. Required partners included two major state agencies, the Department of Social and Health Services (which oversees key behavioral health activities) and the Department of Commerce (which supervises several housing initiatives). The list included local governments and nonprofit groups providing various kinds of housing supports as well.

Subsequently, state officials announced that Amerigroup, a leading MCO with operations in several states, had won the bid. Washington Medicaid officials were familiar with Amerigroup because it was one of five Medicaid MCOs in the state. The others were Coordinated Care (Centene), the Community Health Plan of Washington (anchored in a federally qualified community health center), Molina, and United Healthcare. Amerigroup pledged to run the FCS initiative out of an administrative division distinct from those serving its own Medicaid enrollees. To facilitate the state-mandated partnership with the MCOs, Amerigroup is establishing memoranda of understanding with each of them.

In November 2017, state officials informed Amerigroup that they wanted the FCS program to "go live" at the first of the new year. The state had engaged in outreach for about a year prior to this and furnished a list of 80 potential providers to Amerigroup at this time.

Employing a host of workarounds from its usual contracting procedures, Amerigroup moved quickly to sign contracts with these providers. Thanks largely to these initial efforts, clients started enrolling in FCS in February 2018. Meanwhile, Amerigroup moved to expand the network of providers still further and had signed contracts with over 300 of them by mid-2018. Once under contract, the providers receive orientation and training sessions from Amerigroup and the state. Among other things, providers learn how to submit client assessments and bill for the services they deliver.

Amerigroup has made considerable headway in moving toward the enrollment goals of FCS with 4,235 beneficiaries participating in the initiative as of April 2019. Forty-seven percent of these enrollees were receiving housing supports, with the remainder in supportive employment services. Over 300 enrollees were receiving both housing and employment supports. State Medicaid officials use a client scoring system, the Predictive Risk Intelligence SysteM (PRISM), to help evaluate eligibility for FCS. Among other things, the system prioritizes individuals with complex medical needs who are also homeless. The health provider participants in FCS generally have experience with Medicaid eligibility processes and can gain Amerigroup authorization to bill for services fairly quickly. Housing support providers, who commonly have less experience with Medicaid, face more delays in getting Amerigroup authorization.

While the RFP did not precisely articulate the standards and metrics the state would apply in assessing the third-party administrator's FCS performance, waiver documents illuminate several pivotal indicators. These include (but are not limited to):

- engagement in more treatment for mental health problems and substance use disorders among FCS enrollees;
- quality of care metrics for behavioral and physical health conditions (e.g., a Healthcare Effectiveness Data and Information Set, or HEDIS, measure of adherence to antipsychotics for persons with schizophrenia);
- reduction of avoidable emergency department and inpatient hospital utilization among enrollees;
- reductions in per-member, per-month health care expenditures; and
- improved social outcome metrics (e.g., reductions in the homelessness rate among enrollees).

Conclusion

This interim report on Medicaid housing demonstrations in California, Maryland, and Washington has focused primarily on program design. Officials in the three states carefully considered numerous issues as they developed plans and procedures aimed at improving the health of people who are homeless or precariously housed while also paring Medicaid costs, primarily by reducing emergency department use and hospital admissions. In broad terms, California and

Maryland built their programs as locally driven intergovernmental grant initiatives. State officials paid careful attention to developing criteria for local government participation as expressed in their RFPs. The RFPs elicited substantial participation by localities with significant problems of homelessness and related housing problems. In contrast, Washington state officials opted for a design based on contracting with a private sector third party as the single administrator for the state. The winning bidder, Amerigroup, has moved quickly to sign contracts with providers and enroll individuals in FCS. The available evidence suggests that the initiative is off to a promising start.

Whether the housing support designs, however well intended and conceived, lead to the expected implementation actions and produce the desired results remains an open question at this point. Research has repeatedly shown how implementation processes shape the contours and fortunes of public initiatives at times for the better and at times for the worse.[10] The next phase of our research, which draws extensively on our interviews, explicitly addresses this issue by focusing on the start-up implementation challenges of the housing support waivers and the strategies officials used to cope with them. In addition to the three states examined in this report, it will incorporate evidence from Illinois. We anticipate that the results of our research will be available in early 2020.

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[10] The seminal work on policy implementation is Pressman and Wildavsky (1973). Application of implementation analysis to health policy can be found in Thompson (1981).

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