TEMPLATE FOR TRANSFORMATION PROJECT SUGGESTIONS

Contact Information	Project Contact: Lauren Platt, Providence Health & Services, lauren.platt@providence.org 425-525-5734
Project Title	**Housing Stability Pay For Success Proposal: Create new housing opportunities for the highest cost, persistently homeless Medicaid beneficiaries**

Rationale for the Project

Problem statement

Medicaid beneficiaries with the highest levels of unscheduled utilization are often unstably housed. The lack of stable housing for these high risk members raises the cost of downstream medical, behavioral, and social services. While much attention has been paid to the need for services and supports to connect these individuals with housing services, in many instances, a significant shortage in the stock of affordable housing means that we have a very limited ability to ultimately ensure stable housing for these populations, even with excellent case management services. A means of attracting investment to housing with services for high risk members is needed to break this cycle, and to bolster our investment in case coordination services themselves. Increasing housing stability will result in lower net costs and help shift the budgetary equilibrium away from expensive and reactive institutional care toward preventive services. We propose that continuous days of housing should be a success metric tracked by organizations at risk for health outcomes. We propose that a stability incentive should be funded by the State specifically for high risk Medicaid members and payable to organizations providing permanent housing for these members.

Supporting research

Many recent studies have highlighted the association between permanent supportive housing and decreased Medicaid expenditures, which have also been used to support Washington's Supportive Housing Medicaid benefit also included in the waiver. For example, a study based on claims data from Oregon demonstrated significantly lower overall health care expenditures for homeless people after moving into supportive housing. The savings were driven primarily by reductions in inpatient and emergency care.[1] Looking beyond the Medicaid budget, Santa Clara County, California commissioned a 5 year study on the total budget impact of homelessness across Medical, Behavioral and Social budgets (http://economicrt.org/publication/home-not-found/). This study found that providing permanent housing with services for chronically homeless individuals in the top two deciles of total spend generated a savings of over $42,000 annually.

Relationship to federal objectives for Medicaid with particular attention to how this project benefits Medicaid beneficiaries.

We believe that through increasing access to stable housing for high-risk homeless Medicaid members, these members will see improved health outcomes and reduced costs due to decrease usage of emergency health care services, such as reduced ED utilization and fewer inpatient hospital stays, helping Washington achieve the triple aim. Due to the high proportion of overall Medicaid spend attributed to these individuals, we believe that focusing funds on an incentive payment to help these individuals specifically will have a significant impact on total Medicaid spend in the state overall.

Project Description

Which Medicaid Transformation Goals are supported by this project/intervention? Check box(es)

We believe that all goals apply to this project, as listed below:

- ✓ Reduce avoidable use of intensive services
- ✓ Improve population health, focused on prevention
- ✓ Accelerate transition to value-based payment
- ✓ Ensure Medicaid per-capita growth is below national trends

Which Transformation Project Domain(s) are involved? Check box(es)

[1] Wright, Bill et al. *Formerly Homeless People Had Lower Overall Health Care Expenditures After Moving Into Supportive Housing.* Health Affairs. January 2016 35:120-27.

- ✓ Care Delivery Redesign
- ✓ Population Health Improvement—prevention activities

Region(s) and sub-population(s) impacted by the project
Based on our knowledge of community partnerships and current projects being pursued by the City and our own health system in Snohomish County, the greater Northwest Washington region and the City of Everett, we believe that partners in the North Sound region would be poised to integrate this approach in to their work quickly. However, we believe this model could work in other areas of the state as well given the right parties are at the table.

The project will focus on the chronically homeless, as defined by HUD (below) and could focus on those individuals with higher than average medical claims costs, as defined by: 10 times the average total annual claims cost as measured over trailing 12 months **AND** at least 1 of the following:

- 2+ in-patient hospital visits/ 12 months, **OR**
- 3+ ED visits over 6 months, **OR**
- 5+ ED visits over 12 months

Chronically Homeless as defined by HUD, includes: "Either (1) an unaccompanied homeless individual with a disabling condition who has been continuously homeless for a year or more, OR (2) an unaccompanied individual with a disabling condition who has had at least four episodes of homelessness in the past three years."

Relationship to Washington's Medicaid Transformation goals.
By securing stable housing for high-risk, persistently homeless Medicaid beneficiaries, we believe we will reduce emergency room visits, inpatient hospital and psychiatric stays, thereby **reducing avoidable use of intensive services and settings** in favor of higher utilization of preventative services. By focusing the intervention on persistently homeless Medicaid beneficiaries, we will **improve population health with a focus on management of mental illness and substance use disorders** in particular. By tying the incentive payment to metrics for stable housing for these individuals in addition to housing quality, we are pursuing this solution as a **value-based payment** rather than payment for services. By achieving the reductions in avoidable, costly utilization of intensive services in favor of access to more, we would provide a significant return on investment, contributing to the state's goal of **decreasing the Medicaid per-capita growth trend by two percentage points below national trends**.

Project goals, interventions and outcomes expected during the waiver period, including relationship to improving health equity /reducing health disparities.
The goals of this project are three-fold: 1) Increase the length of time that persistently homeless, high-risk Medicaid beneficiaries are housed with a goal of transitioning 2,000 high risk, chronically homeless Medicaid members to stable housing with services ; 2) improve health outcomes for these members and reduce the total cost of social, behavioral, and medical services to support these individuals, which we believe will be achieved through reduced emergency room visits, inpatient hospital and inpatient psychiatric hospital stays; and 3) create a pay for success-type model that attracts private investment to sustain stable housing for these individuals over the long-term.

The intervention is days stably housed for these individuals, provided similar to a "housing first" approach, and measured in days continuously housed. The mechanism with which the intervention is provided is through the use of an incentive payment, similar to that used in the Santa Clara study, which would be paid out based on milestones linked to the number of months a landlord or entity is able to stably house a chronically-homeless Medicaid client. This incentive payment can then be used to pay for building maintenance and improvements, and/or to contract with entities to provide supportive services for these individuals. The payment can be phased in, so that the first payment is upon an individual being stably housed for three months, with the monthly payment varying to incentivize consistent housing for these individuals.

Expected outcomes include:

- Increase in days stably housed for these individuals
- Increase in the supply of housing for the chronically-homeless, high-risk Medicaid population
- Improved health outcomes for the population, measured by ED utilization, inpatient hospital visits, and inpatient psychiatric visits

- Decreased medical spend for this population within the Medicaid budget
- Decreased spending in social supports that accrue to other state agency budgets, such as corrections, and behavioral health services

Links to complementary transformation initiatives

- Initiative 3: Supportive Housing and Supported Employment – this project, while similar in some ways to supportive housing, would open up housing units outside of current supportive housing facilities that could stably house individuals while providing connections to supportive housing supports. This could help leverage the state's investment in supportive housing.
- We also believe this will support a number of ACH project proposals focusing on the social determinants of health.

Potential partners, systems, and organizations

In Snohomish and Everett, we have worked with DESC, Mercy Housing Northwest, Compass Housing, Housing Hope, and Providence Supportive Housing among others on finding a solution to the regions housing needs. In other communities, we believe it's essential for homelessness and housing organizations and major health care providers in the area to be at the table for a successful project.

Core Investment Components

Describe:

Proposed activities and cost estimates ("order of magnitude") for the project, including: best estimate for how many people you expect to serve, on a monthly or annual basis, when fully implemented and how much you expect the program to cost per person served, on a monthly or annual basis:

The primary activity would be a stability payment, which would average out to $1,000 per member per month if members are housed continuously for one year, or $12,000 annually. This is estimated based on the Santa Clara study. We propose that this payment be allocated for 825 chronically homeless individuals each year for five years. The number of individuals is based on the Department of Commerce 2105 Point in Time Count for WA, which estimates 19,418 homeless individuals across the state. Based on HUD estimates that roughly 17% of all homeless are chronically homeless, we are proposing to serve roughly 25% of the chronically homeless in the state, to consider take-up rate and other eligibility criteria tied to medical spend. Therefore, the total cost per month once fully implemented would be $825,000, $9.9 million annually, and $39.6 million over the course of the 5-year grant period (assuming that full implementation covers 4 of those years, with one-year for ramp-up time). We propose that Medicaid could partner with other state agencies to contribute a portion of the program costs, as data from the Santa Clara study pointed to roughly half of the ROI accruing to the Medicaid budget, with the other half coming from other state budgets. Program evaluation and funding for program delivery such as staff assigned to the project are not included in this estimate. The monthly payment is slightly decreased from that in the Santa Clara study to adjust for a decreased cost of living in WA state on average, however the total incentive payment could be adjusted according to further review of an effective incentive rate for housing providers would be in interested communities.

How long it will take to fully implement the project within a region where you expect it will have to be phased in.

We expect the program could be fully implemented in 12 months once a community has chosen this project.

The financial return on investment (ROI) opportunity, including estimated amounts and associated ROI timeline.

Based on the estimated cost of $12,000 per member per year, and based on the ROI data included in the Santa Clara County study, we estimate net savings to the State of $28,000 per member housed. With total annual costs of $12,000 per member, the program would yield an ROI of over 230%.

Project Metrics

The State will monitor implementation of transformation projects at regional and statewide levels through process and outcome measures. Each project will require clearly defined outcomes that relate to the goals and specific process steps. Wherever possible describe:

- *Key process and outcome measures (and specific benchmark performance data if known) against which the performance of the project would be measured. Include priority measures sets described in the Waiver application*,
- *If no specific benchmark performance data are currently available, what efforts will be undertaken to establish benchmark performance ahead of any proposed project implementation*?

The key metric will be continuous days housed for high risk, chronically homeless Medicaid members. High risk members are defined as those with 10 times the average total annual claims cost as measured over trailing 12 months **AND** at least 1 of the following:

- 2+ in-patient hospital visits/ 12 months, **OR**
- 3+ ED visits over 6 months, **OR**
- 5+ ED visits over 12 months

Process measures would also need to be defined to ensure that the housing is safe from a social and environmental perspective. In order to establish these criteria, we propose working with Housing partners and our own Providence Supportive Housing Services to define quality metrics we can use as eligibility criteria for entities to receive this stability incentive payment.