

Demonstrating the Impact of Supportive Housing Audio Transcript August 7, 2019

Welcome and Background

MELANIE BROWN: Thank you, Christina. Good afternoon, everyone. I'm Melanie Brown with the Medicaid IAP program of CMS. The purpose of today's webinar is for participants to learn the advantages of measuring outcomes to assess the impact of supportive housing. We also hope you'll become more familiar with measures used to assess the impact of supportive housing, that you'll understand some of the considerations associated with measuring supportive housing outcomes, and will learn from the experience of two state Medicaid directors involved in this work. We'll start with a polling question: We'd like to get a sense of joining us today. *Who is joining us? Please indicate whether you're* from the: state Medicaid agency, state housing agency, other state agency, regional or local housing organization, regional or local support/service provider, managed care organization, advocacy organization or other. The majority of our participants today represent advocacy organizations followed by other state agencies as well as state Medicaid agencies and state housing agencies. Welcome to you all. We hope that you'll find the content that we have for you helpful.

The agenda for today includes:

- Welcome and background about the IAP.
- Framework for demonstrating the impact of supportive housing.
- States who have used this framework or a similar one to this.
- Frequently used outcome measures to measure the impact of supportive housing.
- States perspective.
- Questions and answers.
- Closing remarks and evaluation.

[intro to IAP/logistics]

The State Medicaid Housing Agency Partnerships Track is one of our technical support initiatives that falls under the umbrella of the IAP priority area called Community-Integration through Long-term Services and Supports (LTSS). Our goals include increasing state adoption of individual tenancy sustained services to assist Medicaid beneficiaries, facilitating partnerships with housing agencies and increasing state adoption of strategies that tie together quality, cost and outcomes in support of community-based LTSS programs.

Consistent with statute, CMS does not provide federal financial participation for room and board in home- and community-based services. The focus of the technical support that states received tends to revolve around peer-to-peer learning opportunities as well as helping states identify goals and resources that can assist them and creating and implementing action plans.

We are currently providing technical support to our third cohort of states. We've provided technical support to a total of 19 states since 2015 and the graphic on the screen highlights those states.

Some of the key accomplishments of the State Medicaid and Housing Agency Partnership track include: establishing Medicaid and housing across agency partnerships; aligning existing housing and healthcare policies; developing or expanding data matching to target resources, examine costs, and measure the

impact of supportive housing; and developing policies and mechanisms to increase supportive housing and other community living opportunities.

Framework for Demonstrating the Impact of Supportive Housing

Now Kathy Moses, Associate Director of Policy with the Center for Healthcare Strategies, will talk about the framework for demonstrating the impact of supportive housing.

KATHY MOSES: I have worked with the IAP since its inception. Our organization has served as a coach to the states for all three cohorts and I'm excited to talk about demonstrating the impact of supportive housing and what are some of the things we need to do to get started.

First, what are the benefits? Why would we measure the impact of supportive housing? To underscore the results of the survey (polling question 1), this particular type of work is not singularly housed in Medicaid or the housing agency, it really is a partnership. Because of that, everyone owns a piece but doesn't own all of it, and that's why the partnership is so valuable. Keeping that in the back of our minds, that's an important piece of why we're measuring and keeping in mind who we're trying to communicate with in terms of our outcome measures.

That's the first bullet here. We're measuring the impact of supportive housing across different siloes, different geographies, different populations, and need to have foresight into what it is we want to communicate so that we are collecting it. In some states, in some places, it is important to be able to determine or demonstrate the effectiveness of supportive housing services. In other states it may be something else, it may be more about costs. These next two bullets are about cost, both looking at individuals who are stably housed versus those who are unhoused, and then in addition to the individual level or groups of individuals, just looking across the healthcare system as a whole and where are the costs being reduced or increased given these services. Last but not least we're also interested in looking at how we can increase community integration through supportive housing, again recalling that it is a cast of many and is successful when everyone is working together knowing that we're bringing things closer together for the community, as a community, is important as well.

[interruption for technical issue re slides]

When we think about the impact of supportive housing, we think about increasing and decreasing different things. Hopefully with the services being provided there is an increase to cost savings, an increase to overall collaboration across the health system, and for individuals an increase in quality of life and self-sufficiency. On the other side of the scale, we're hoping to detect a decrease in shelter usage, jail recidivism, and misuse of health systems.

In terms of what we need to measure, one of the first questions a state needs to ask themselves or group of parties that come together as partners need to ask themselves is who is the target population? This is not necessarily always an easy question. It may be that there is a governor's level mandate or a legislative interest in a particular group or population and that's where the initial traction takes place. With that it's important that we know what the drivers are--what are we trying to achieve?

It could be a strong interest in reducing emergency department visits or inpatient hospital stays. The main driver could be improving health outcomes or stability for tenants. More than likely it's more than one of these but it's important to think about where's the charge coming from and what needs to be measured so we can then do the best job of picking indicators for these goals.

The next thing that needs to happen is identifying data sources. On this next slide are a couple examples of data sources. Of course there's the Medicaid Management Information System (MMIS), the Homeless

Management Information System (HMIS), but there are also clinics and emergency department (ED) data sources as well as behavioral health, substance abuse, jails, courts, transportation, so a variety of sources. Generally, it's the more the merrier, but oftentimes we can't let the perfect get in the way of good in getting all these data sources together under one roof and most importantly thinking about it as an iterative process in order to start to paint a really good picture of the population we're trying to work with.

Talking about the target population a little bit more here, again thinking back to what is our driver? What is really helping us move this forward? Is it a governor's or Medicaid or housing initiative? Is there a legislative requirement to focus on a certain group of individuals that makes it the logical place to start? A lot of times there are high-cost users who are targeted but it can also be from the medical complexity--beneficiaries who have really complex needs, or individuals with high homelessness recidivism, those who just keep cycling in and out and spending a long time in homelessness who may be the initial target population. And again it's not limited to one, it could be many. But it is important to think about who are we targeting so that we can think about providing access to the right data.

The next thing under ensuring access to the data, one of the most important steps and probably time-consuming steps is developing data sharing and data use agreements. We'll hear from states on the line today that starting early is important to make sure that we get plenty of time to finalize agreements and move forward with them. Another tip really is leveraging existing opportunities. Should there be something that's been started, maybe data sharing with the health plans or data sharing with a small piece of the HMIS, that could also be a place to start and build on that. But it is very important to develop those relationships and get everyone pointed in the same direction because it does take time and has multiple levels of approval.

One other note, if including substance use data, it is an additional consideration in terms of the privacy laws around that and making sure that is considered in advance as well.

(next slide) As far as methodology, again it's important to think about what we're trying to accomplish and what we want to be able to evaluate or study in terms of these outcome measures. So understanding, based on the size of the beneficiaries we're looking to cover, the target population, if we need a sample size, if there's a certain sampling methodology that we want to look at to accomplish our goals. There are a couple of different types and you probably know these different types of studies. A pre/post-test, which can be helpful in terms of seeing changes in the target population, looking at controls and comparison groups. Sometimes a randomized control trial is merited. That and the longitudinal studies are obviously longer and take more money and more time to accomplish, but in some cases that is what is needed. So being mindful of who you're speaking to with your study or evaluation is also a key piece in considering these study methodologies.

(next slide) I'll turn this over for a few minutes to Judy Mohr Peterson, the Director of Medicaid in the State of Hawai'i, and Kate McEvoy, the Medicaid Director in Connecticut. Both very personally and actively participated in IAP in cohort one with their states, and they each have very different stories. Judy is one of soup to nuts under their time with IAP starting with meeting the partners at the table and working with them to develop some services and a program, and with Kate in Connecticut, they came to the table as partners already and had been working together and built upon some of those experiences and data sharing knowledge. I think they offer really complementary perspectives on how states come together and partner, and within the state come together and partner on housing services.

JUDY MOHR PETERSON: Kate and I were from the beginning in the first cohort and very appreciative of that opportunity to participate. We learned a lot. There was a lot of great targeted technical assistance

and without that I don't think we would have gotten it off the ground. I appreciate the perspective of what it takes to get started. I know you started off outlining what it takes to get started measuring the benefits, but I'm going to outline a couple of other things I think are really key to getting things together and use examples from our state in Hawaii.

First, even before you start thinking about your tactical goals you're trying to accomplish, really it's important to think about what the overarching goal is (you're) trying to achieve. You need that and you need that agreement amongst your partners because we're bringing together, at least in Hawai'i, people who normally--we work in completely different areas. We have our own sets of acronyms, our own sets of languages and authorities and what we can do and not do. Sometimes we're using the same words, but we mean completely different things like what permanent supportive housing means and Medicaid is actually not paying for permanent housing, which comes as a surprise to housing people. So having an understanding of what your overarching goal is of what you're trying to achieve is really important so that as you're dealing with your various frustrations or trying to figure out what are they saying, you can point to--this is the direction we're going, this is why we're doing this, etc.

In Hawai'i we have the highest per capita homeless population in the country. So addressing homelessness is a key governor priority, legislative priority, and each of our agencies' priority. When the opportunity came up to take a look at different ways of providing or building on these community integration services, we really took that up as a way in which to address that strong connection between health and housing. We first wanted to target working with the chronic homeless population, because they're the ones who are using the healthcare services more than other populations.

In thinking about that target population, it also makes a difference when you're thinking about what kind of costs you're going to incur or that concept of return on investment. The more acute--the more people have really complex health needs, then the more cost savings you're likely to achieve by the reduction of the use of acute healthcare services like hospitalization or emergency room use. The more that you target a population that is perhaps at risk of homelessness or does not have as severe health needs, then you're not going to see the same kind of savings and in fact you may actually see an increase in some of your costs.

So in bringing together all the different partners as was said before, it takes a lot of work to do that. So having a clear goal that you're setting your sights on, being really clear about what your target population is, developing those relationships always is key, building up those trust relationships. Even before I can start working on a data share agreement with someone, it goes a lot better if we've been working together, if we've already been working on establishing those shared relationships, shared literacy about the terms, etc., and that we have a shared vision and goal of where we're trying to go.

A couple other areas I would want to focus on and emphasize is that in the health outcomes area, and we'll talk more about this in a little bit, but in that particular area it actually isn't a decrease in health utilization. Our expectation in working on this is actually that you would see a decrease in the use/misuse of emergency room use, and that is indeed what we've started to see, and a decrease in the use of inpatient care. But we would also expect to see an increase in primary care, in preventive care, in mental health care, and substance use disorder types of treatment. Hopefully less of the crisis and more of that primary care and behavioral health recovery services.

So you really do need to bring all these folks together. We were talking about the housing folks and Medicaid and that certainly is an area that needs a lot of focus, as well as with the social service agencies working with the homeless population. But the other area, at least for us in our Medicaid

program, is to work with our sister agencies who provide the behavioral health services and the behavioral health policy areas.

MELANIE STARNES: Maybe you can share more later and Kate can talk about the getting started piece.

JUDY MOHR PETERSON: Sure. There are huge data challenges and Kate can talk a lot about that.

KATE MCEVOY: I want to echo the praise for the IAP. It has incredible utility for us, for states at any stage of development in this type of work. It is complex and requires a lot of synthesis of different policy aspects, authority, funding. The protected space you have with IAP is a real gift for giving you that opportunity to really dig in. I resonated so much with the themes Judy sounded, particularly starting with the context piece. For us we were able to really fit in with our existing health reform agenda, our efforts around elimination of homelessness, and also justice reform. So being informed by how these strands all relate, very, very important. Also totally agree and resonate with what Judy said about shared literacy and trust basis, so much leaps off that, and IAP was remarkably facilitative of that for all of us who have participated.

Just building on what Judy said, from the standpoint of where we thought it was useful to start at the threshold, inventorying existing interventions and sources of data as Judy began to talk about, are useful. In Connecticut we had already existing state-funded portfolio of supportive housing that had many years of experience and some data associated with it. We also had longitudinal data from our Money Follows the Person (MFP) initiative. We have a Housing Plus Services MFP initiative that marries a Medicaid home- and community-based services with housing vouchers, so we were able to really identify and build from that, as well as two privately funded pilots.

We essentially were starting in the strong position of having proved our hypothesis at the outset, the proposition that stabilized housing improves the capacity of people with complex needs to engage in their healthcare, to improve outcomes, and to improve their life satisfaction and care experience. So looking at what you already have in place, even if it's on a modest scale, is very important. Then the absolutely essential next step, which was flagged just a moment ago, is data matching. We were able to match our fully integrated Medicaid claims data set with our fully statewide HMIS data set. The benefit of my learning was you don't know what that data is going to show you and it is revelatory. So disabusing ourselves of preconceptions of who might emerge in the match is very useful.

The final thing I'll say is from the inception point we deliberately framed it as transcending specific budget lenses. This was not simply about Medicaid impact and potential savings or housing impact and savings. We purposely braided our approach in terms of making the case for Medicaid authority and funding in the state budget. We urged our budget folks to lift themselves out of their specific orientation, and really it is about braiding resources, Medicaid and those housing vouchers. So that's a very useful thing to think about at the conception point so you're prepared to overcome some of these silos that have impaired us historically.

MELANIE BROWN: Thank you for that useful information. We'll check the chat box for questions. The first question: *I notice that IAP is not working with any states in the Southeast through this program. Is there an effort to work with one or more states in this area to develop capacity to participate in this cohort?*

I'll take that. Typically all states are invited to apply to participate in our IAP cohorts under the Community-Integration through Long-term Services and Supports, so the level of geographic diversity is largely dependent on states that apply to participate. I believe with the exception of perhaps the first cohort, where we had over 25 states apply, most states that apply for support are invited to join the

track. The only exceptions might be if the type of technical support that the state needs is not a good fit for the type of technical support we could provide. That said, if you have a state that is interested please check our Medicaid.gov updates. Typically that's how new tracks or technical support initiatives for IAP are announced.

I am interested in any specific thoughts on addressing the research gaps identified by the National Academies of Science, Engineering and Medicine 2018 Report, Permanent Supportive Housing, Evaluating Evidence for Improving Health Outcomes Among People Experiencing Chronic Homelessness.

I don't know if there's a specific question there. I invite our panelists to respond, but it may be helpful for the person posing that question if you have a specific question to enter that in our chat box.

KATE MCEVOY: Just briefly, we do really have challenges with capturing that entirety of experience for people who are not stably housed and we all have a lot of humility around this, particularly around the touchpoints with healthcare. In fact, we may see people who are severely underutilizing healthcare other than emergency room visits. So I think there are definitely some built-in challenges there. I know in many states they don't have the luxury of having an existing state-funded supportive housing portfolio from which you can draw lessons and from which data has emerged. But there are some states that now have longitudinal data. As I remarked, our MFP data, our state-funded portfolio, also the private pilots we have done, really are a source of information and we'd love you to be able to analogize to our experience. That is now getting a bit more solidified as states are having more experience.

MELANIE STARNS: There was also a question about braided funding for the states. *How did Connecticut or Hawaii get braided funding into their budget?*

KATE MCEVOY: I certainly used the generous term of braiding. It's not precisely braiding in the standpoint of creating a flexible pool from which dollars can be elastically applied. What we did do is essentially frame this as a proposal for our budget office to cover supportive housing services under Medicaid that would necessarily involve both Medicaid services and new housing vouchers. We actually had distinct analysts in our budget office who handled each of those different domains of work and we really got them on deck at an early juncture point to say we'd like to make sure this is proposed in concert. We framed out the return on investment cognizant of both of those areas of spend, and the Governor's proposal in our budget cross referenced the two items across departments in order to illustrate the interrelationship of it. So the Legislature was asked to really appropriate funds on that basis, not simply in a silo of one department's budget.

MELANIE BROWN: We're out of questions. I will turn it over to Melanie Starns, our Senior Director from IBM Watson Health responsible for our State Medicaid and Housing Agency Partnerships Track. She's going to talk about outcome measures frequently used to demonstrate the impact of supportive housing.

[Outcome Measures Frequently Used to Demonstrate the Impact of Supportive Housing](#)

MELANIE STARNS: This section of the webinar is going to provide some of the specific measures that states, and localities have used, so it's not necessarily a state or that everybody's done it statewide. Some of it may be cities, some may be counties, some a region of a state. But if you are looking to do this kind of work it's valuable to see the range of different types of measures that folks have used over the years to assess and demonstrate the impact supportive housing has had on a variety of different pieces.

We have four areas we're looking at here including measures around healthcare utilization, around homelessness because that is a common target population, a couple things on tenancy, and then around

law enforcement and criminal justice. What you're looking for here is if you look at this measure what kind of change would you expect to see due to the use of supportive housing.

We have several around healthcare utilization. The first one is a measure looking at emergency department visits. With supportive housing usage you would expect to see a reduction in the number of visits and then of course the cost for visits as well. One of the other things we look at is hospital inpatient admissions and again with supportive housing, people in supportive housing are more stable, we typically would expect to see a reduction in the number and costs of hospitalizations, less intense if they do need it. Then inpatient hospital stays, you've got admission and the length of stay you're measuring and the cost of that, and we would expect to see a change, a reduction in the length of stays and costs associated with that.

Also looking around behavioral health, so looking at psychiatric inpatient hospital stays, their frequency and duration. We would expect to see a reduction in the use of mental health crisis services for folks using supportive housing. We would expect to see a reduction in psychiatric inpatient hospitalizations and associated healthcare costs. We would expect to see improvement in mental health outcomes, and there are a number of states that have looked at different things with that. And also a reduction in the duration of psychiatric hospital stays, so not preventing it entirely but maybe those stays are shortened.

Another measure in healthcare utilization costs is looking at outpatient mental health service utilization. This is one of those interesting ones that while you may see a reduction, the second bullet on the right, you may see a reduction in overall mental health service costs, you may actually see an increase initially in the use of outpatient mental health services. Because people, as they start to shift from using crisis services and emergency department services, they switch to outpatient and more appropriate services because other things in their life are stable, and you may see an increase in outpatient mental health services. That's an important thing to mention, particularly in state government. If we do supportive housing, we can see some shifts and better outcomes and perhaps cost savings, and then if you have an increase in a particular area it's important to make sure leadership is aware of that possibility. Typically, the research indicates that over the course of 1-2 years those costs kind of level out as everything gets stable and those shifts are finalized.

Finally, in healthcare utilization, states looked at substance use disorder, the use of detoxification services. They would expect to see a reduction in the use of detox services and a reduction in healthcare costs for detox services and interventions. This is not indicating that you cannot have substance use disorders or use substances in supportive housing, but they have found that once people are in supportive housing they need less of these services. Then with the use of emergency medical services, we expect to see a reduction in the use and cost of those services for people in supportive housing.

A couple of measures around homelessness. You might obviously expect the number of people experiencing homelessness to have a reduction if people are housed and not on the streets. That's a straightforward one there. The length of time people remain homeless as they're obviously in supportive housing would go down as well. Then emergency shelter use, we would expect to see a reduction in housing costs. Emergency shelters can be very expensive to run, and then a decrease in the number of days of shelter use obviously when folks are in supportive housing.

A couple measures around tenancy. You can see that not everything is necessarily about healthcare utilization. So, one of the measures states have used was looking at the tenure in supportive housing, how long have they been in supportive housing, and they're seeing a correlation between the length of time folks are in supportive housing and then the decrease in healthcare costs with the increase in

housing. Also, the longer they're in housing they're seeing a reduction in the rate of return to homelessness, so the longer they're in housing the further away from homelessness folks tend to get.

Another interesting one kind of off the beaten path is some localities looked at the change in tenants' income and they actually found that to be a quite useful measure, and found that there was a positive correlation between the increased income and housing retention. So, something a little different-- (a) measure that states found pretty useful.

States also look at law enforcement and criminal justice. Some states looked at arrest rates for those in supportive housing compared to those who were not. They found that there was a decreased rate of arrest among those in supportive housing and a decrease in law enforcement costs related to those in supportive housing. Those are outside the healthcare arena for sure.

When we looked even further at the cost of incarceration and jail services for those in supportive housing compared to non-supportive housing individuals, a couple things they found were a reduction in incarceration-related healthcare costs. Of course people are not in prisons or jails and the healthcare costs go down. Then another big impact was reduction in community reentry housing location costs. Those who work in that arena know that (it) can be quite a challenge and a lengthy and somewhat extensive process to help ex-prisoners find housing and for folks released moving back into the community.

To illustrate what a couple states have done with these types of measures, we have a couple examples. In Massachusetts in 2017 they did a study of people experiencing chronic homelessness and they found that for every dollar they spent on supportive housing and case management services, it translated into as much as \$2.43 in savings due to reductions in other types of healthcare services use. That's a pretty good rate of return on that.

In Connecticut in 2018 they reported that overnight hospitalization, one of the measures we looked at, among Medicaid beneficiaries dropped from 8.5 incidences in the 12-month period before they were in supportive housing to just 2.7 incidences in the 12 months after they were in supportive housing, so a pretty significant decrease. The emergency department visits also decreased from 13 the year before housing to just 5 in the 12 months after housing.

Those are specific measures. Kate, this last slide talks about work that happened in your state, so we'll go back to Kate and Judy now. What else can you share with us about what Medicaid has been doing and the impact you've seen in your state from supportive housing?

KATE MCEVOY: That was an important inventory of important focus areas of measurements for all states. Certainly those were very high on our radar screen in terms of the original framework. Leaping off that last slide, I want to credit the Corporation for Supportive Housing and the Connecticut Coalition on Homelessness for really approaching our department, the Medicaid agency, not only around data matching but on partnering to examine the results of what became two pilots, which were designed to illustrate impact from supportive housing interventions.

Part of the staging of those pilots, one of which was funded by the Social Innovation Fund, was really to develop a measure framework for assessing impact. So many of the features of what you discussed, Melanie, really figured prominently there. This slide captures only two indicators related to acute care but I want to reinforce what you said, that taking an expansive view of this was really important. Not only with the reduction of the acute costs related to hospitals but in Connecticut we have seen these set of interventions intercepting a cycle that we were often experiencing where individuals with complex needs went into the hospital via the emergency room, were discharged to skilled nursing facilities (SNF),

and then discharged because of an inability to meet level of care requirements for Medicaid, back to unstable housing or homelessness. So the experience with SNF care also is something that was very important for us to pay attention to.

Correspondingly, on the end of proving out the efficacy of the intervention, you do want to be interested in gauging whether there is uptick of the preventive services. Back to what Judy said earlier, you may see amplification of costs based on people who have not historically had the access and benefit of prevention, particularly around management of chronic conditions. So not only are those sort of process measures of people approaching and being served by preventive not only medical care but behavioral healthcare, but indicators we can look at in HEDIS and other measures around the utilization of healthcare in support of conditions like diabetes, which often co-occur with behavioral health conditions and which we found in our target population identified through data match are ubiquitous.

Another area that I just wanted to touch on is something I hold very dear and really wish was more often considered, co-equally situated to the savings figures to the impact from a standpoint of finances and housing stability and the reduction of acute costs, and that is a formal means of evaluating care experience and also life satisfaction. Briefly we used a very, very high incidence of CAP surveys for that purpose. We also use a life satisfaction scale we have for many, many years with our MFP initiative, really to gauge our people by their own report better off in stabilized housing. Marrying up these different indicators really presents an extensive worldview of the improvements you can achieve. Judy, how do you respond and how are you applying it in Hawai'i?

JUDY MOHR PETERSON: I really wholeheartedly agree with everything you outlined and that Melanie covered. I have to say we are at an earlier phase so we don't have already the beginning of a bunch of data. We do have some early, early indicators. That's the other aspect of it as well. While we can focus on outcome measures, it's also important to be tracking those more interim process metrics so you can do some rapid cycle improvements as you're moving along.

Some of the other aspects I think are related to that concept of care experience are also even measuring things like prison engagement. A lot of times it takes quite a bit of work before you can even start on this concept of getting somebody housed. You're just simply trying to build up trust with those individuals as they're living on the streets, etc. And it's important to be tracking that to see how long it does take to engage with individuals. Are you being successful in those efforts? Do you need to think about doing them differently with different folks?

The other kind of metrics, the interim metrics we have found are also important to be able to tell the story of the success, (and) have to do with how long people are housed once they get the housing. So how long does that take to get engaged? How long does it take to find housing and how much housing is there? How long are people able to retain their housing once they achieve it? For Medicaid agencies, these are not the kind of metrics we normally look at, but they are very essential in working on this kind of project.

Circling back to the behavioral health areas, there are people engaged with their mental health professional or substance use professional or which is often the case, the dual diagnosis. A lot of folks, at least in Hawaii, with the most complex health needs are also suffering from wounds, and that takes a very specialized healthcare treatment system to be able to provide those services as well. So, focusing on how long people have to stay or how they're able to address their wound care and infections is also important.

On the data sources, it is important to get those data sharing agreements. It's also important to recognize that the data quality of those resources might be not quite what you were expecting, either

on the health side with the claims data we have access to, marrying that up with HMIS. They may have the data in different kinds of ways and may have gaps in the data, etc. So, in order to get to these metrics, figuring out the data sources, the data quality can also be challenging. Not that you shouldn't do it but of course you should do it, but just be aware that that's another issue you have to work through.

Working with behavioral health partners was mentioned quite a bit earlier. Figuring out the limitations and how it is that you can share data around substance use is always tricky. It has taken quite a bit of work on our part to be able to work that through. That's even with really strong relationships it just takes a lot of time and work to figure that out.

We've been talking a lot about cost savings, and this gets to Kate, what you were covering on braiding. It's that recognition that in some programs you're going to actually see an increase in investment and an increase in costs, etc., but the savings might accrue to a different program. Knowing that and paying attention to that is going to be important for state agencies. Then also understanding that some of the goals you're trying to accomplish, they may not result in cost savings. But from a policy perspective, they're accomplishing these other larger goals. So being able to state that and being able to tie that then to the outcomes you're trying to accomplish is also going to be a very, very important thing to be able to measure and to evaluate and put forward. If you have increased costs, that's okay as long as it was part of the recognition from the outset that that may happen. Then also for all the budget people out there, being able to talk about the difference between cost savings and cost avoidance is always important.

Questions

MELANIE BROWN: We have lots of questions, more than we can get through. I'll try to combine some questions I think are related. We will make the slides available. They are typically posted on Medicaid.gov on the IAP page within about two weeks of the webinar. Lots of people asked about references, specifically the statistics referencing Massachusetts and Connecticut. The best way to do that is have them reach out directly for that information.

MELANIE STARNES: They're welcome to do that and we can add those citations for those two studies, Massachusetts and Connecticut, to the information posted as well.

MELANIE BROWN: There was a question about the MFP program. MFP is a CMS-administered demonstration grant program. Its primary purpose is to help states transition individuals who are in nursing homes into community living settings. To date they've worked with approximately 44 of the 50 states. More information is available on Medicaid.gov.

There was also a question about how can we find out what our states have done? The best place to start is the state Medicaid agency. If you're having difficulty identifying a point person, specifically for our 16 states that have participated in cohort one and two, if you go to that Medicaid.gov IAP site we have fact sheets on this page which identify points of contact for our state Medicaid housing agency partnership's work. You can also reach out to Melanie Starnes or myself. Our contact information will be available on the last slide. Let's turn to questions for our panelists.

There were quite a few questions about data collection. For both Connecticut and Hawai'i: *In Connecticut's and Hawai'i's examples, what has the state housing agency's role been in data collection?*

JUDY MOHR PETERSON: Keep in mind that it took us quite a bit of time to get our program approved with the appropriate Medicaid authorities. It took a bit longer than we had anticipated so we officially launched our program starting in January. Up to that point we had been working with a public housing agency that was helpful in providing information about the numbers of people who were on the wait

list, the throughput of how many people were housed on a regular basis. We've not figured out yet if and how we would be able to do any kind of a matching. Rather Hawaii is in the process of working on an agreement with the folks who run our HMIS, as a starting point.

So our public housing agency has been a great partner but we have not figured out the data sharing aspects of it as far as here's a list of people. The one exception is we have been working with them with the information that is publicly available. If there are individuals at risk of eviction we are seeing if any of those individuals might qualify, but again that's at the earlier stage.

KATE MCEVOY: In Connecticut the Medicaid agency is part of a larger omnibus human services agency. We do also have a standalone Department of Housing and they and our sister agency Department of Mental Health and Addiction Services are jointly responsible for creation and oversight of our state-funded supportive housing portfolio, so both those agencies have been very active work group members with us in Medicaid in developing our intervention. They inventory and make the case from a budget standpoint for the housing vouchers of various types that are an essential part of the intervention itself.

We also have involved in our work group our Housing Finance Authority, really cognizant of the fact that they really have the complementary strand of the tax credits, the direct intervention with developers, many of which are looking for solutions, onsite residential support for tenants when they're looking to meet criteria associated with public financing for development. So all those pieces have been really important and we're pretty purposeful about that.

The data from the standpoint of the HMIS is owned and managed by a nonprofit organization, the Connecticut Coalition to End Homelessness. They're the steward of that data, so it's with that entity that our department has to do and handled the data matching piece.

MELANIE BROWN: For both of you: *Were the Hawai'i and Connecticut programs statewide or were certain areas targeted?*

JUDY MOHR PETERSON: In Hawaii, it's been a statewide effort.

KATE MCEVOY: For us also, but due to needing to start somewhere from the standpoint of budget, we did a comprehensive data match that was very, very broad from the standpoint of catching on the homeless system, any incidents of homelessness. We didn't circumscribe that. Then we used the results of that match to tailor a proposed target population, so we had a larger cohort and we selected from that about 850 people who had the highest level of need from presenting co-occurring conditions and also costs already within Medicaid predominantly related to ED, hospital admission and SNF use, and that's where we will place our emphasis and then hopefully build out from there over time. So, it is statewide and has a state focus and we're using a Medicaid state plan authority that enables us to target on the basis of those characteristics that I described.

MELANIE BROWN: For the next question, they're using (the words) cooperative agreement, but I think this is referencing data use agreements as well as MOUs. It says: *How long did it take to get cooperation agreements with law enforcement and homeless provider organizations for data sharing and were there any substance use disorder data sharing issues that arose?*

KATE MCEVOY: For us in Connecticut we were actually approached by the Coalition to End Homelessness. They're the stewards of that data. They were the ones that were the impetus originally for matches that supported the pilot projects I described earlier. So, we were very fortunate to have not only a collegial but really that type of catalyst to move forward with it. They have in place, which might be of interest to people newer to this work, a very effective release form that they ask individuals to sign

as they're served through the coordinated access networks of our homeless intervention system. We were able to utilize those individual releases to frame the use of the data.

Now you can certainly do this on a deidentified basis and that would have been feasible also for us in Medicaid. But I think you're going to get the greatest impact obviously if you can really specifically identify people. The sensitive data is absolutely still constrained by both federal and often state limitations related to privacy, and we really had to predominantly rely on those releases for that purpose, but that is something we're happy to share. We're happy to offer any practical insight we have from our experience. It was not a small thing and you should plan quite an intensive effort around that in most states.

MELANIE BROWN: For Melanie Starns: *Melanie mentioned that self-sufficiency outcomes were observed to be improved. Which exact self-sufficiency measures and how was this measured?*

MELANIE STARNES: I don't think we talked about self-sufficiency. I'm not sure what that person was referring to.

MELANIE BROWN: For the person that proposing that question, you can clarify in the chat box. Kate, specifically regarding Connecticut: *Can Kate expound a bit on how the CAPS survey was modified for your needs?*

KATE MCEVOY: We have not modified CAPS for this particular use. I'm interested in that question and it deserves more discussion. We have used the person-centered medical home CAPS very widely and that is something we have regarded as important as we want to have a nexus to more use of preventive care, but I'd actually like to think about that question. That may be important for all of us to think about how that could be framed in a way that better gets at the access and respect type of provisions that CAPS is intended to illustrate.

MELANIE BROWN: Also re Connecticut: *What kind of study, pre/post matched comparison or RTC was conducted for the outcomes you presented for Connecticut of reduced hospitalizations and ED visits?*

KATE MCAVOY: That was the Corporation for Supportive Housing operating under the Social Innovative Fund. They had worked with us on a data match and CSH did design pre and post comparisons. It was very rigorous. They worked with a researcher in an academic institution and really identified, in particular through use of Medicaid claims data, the impact on incidents of and also costs associated with some of those features of acute care but also the uptake and use of preventive services. We were really able to help them with that because we have a fully statewide set of Medicaid claims data in Connecticut because we're self-insured so that was something we could facilitate for them.

MELANIE BROWN: There's a question about return on investment analytics for the IAP program and whether or not we've looked at the possible benefits to the financial performance of affordable housing. There is actually a national evaluation of IAP as a whole so the entire technical support initiative, not just our focus area. But the focus of the evaluation has largely been around how states are using the technical support and short-term outcomes. We haven't gotten to the point yet where we looked at the impact or return on investment but hopefully we will get there in a future evaluation contract. But the existing evaluation is really focused on process and short-term outcomes.

There's a question about participating states measuring housing stability via HMIS data. Any panelists want to speak to that?

JUDY MOHR PETERSON: I know that's our goal but we're still in early stages.

KATE MCEVOY: We absolutely will want to examine incidents of homelessness for the individual served. We will continue to refresh the data match and that is able to yield identified data, and if we see that phenomena occurring where there's migration on and off to stable housing and then prevention has not been effective in intercepting that, obviously that's going to be something we really need to pay attention to. But our plan is predominantly around designing the intervention so that it is comprehensive and fluid enough so that as people's needs wax and wane based on their circumstances it can be attentive. Like if there's more intensity needed at one point it can be calibrated to that. Then like I said refreshing the data match to see what occurs.

MELANIE BROWN: There's a general question about your state's use of Section 811, Project Rental Assistance Vouchers.

JUDY MOHR PETERSON: Is there a more specific question?

MELANIE BROWN: It just says, *did you use Section 811 vouchers?*

KATE MCEVOY: The answer in Connecticut is yes.

JUDY MOHR PETERSON: They are also being used in Hawai'i as well.

MELANIE BROWN: *How are agencies handling the data once it's been analyzed? In Montana the state Medicaid program will be doing the analysis of the data from all organizations but we're trying to figure out how we can create a data sharing agreement between so many organizations in a timely manner to see how we can share the identified data back to the organizations. How would you handle a situation like this?*

KATE MCEVOY: This is actually where you get down to brass tacks with just how challenging this is. I guess we can say I think it's useful to, as much as possible, to think about whether you have an existing vehicle for individual releases. Like I said, our Coalition to End Homelessness is using an excellent release form that I think has broadened its conception. Also honoring people's privacy that really allowed us to work within that parameter. Then really if there's any help that would be gained from it, I would be very happy to share our documents. We just had to buckle through that, and also feel satisfied that we were adhering to federal standards in particular for Medicaid, the release being in the interests of members and then also the protection of sensitive data. It's not simple and I hear you on everything you're asking about. It's a matter of looking at what others may have done and trying to fit it within your setting.

MELANIE BROWN: There's a question about, *whether or not your projects involved Medicaid managed care and if so in what way?* I think "these projects" is referencing specifically your IAP work.

JUDY MOHR PETERSON: I'll answer because I know Kate does not have Medicaid managed care. In Hawai'i, we're all Medicaid managed care. How we have the Medicaid managed care plan engaged in this project, is we have a requirement that each health plan have at least one, what we're calling a housing coordinator. Someone who can help be that bridge person to the homeless service agencies, to their own case management and care management services working with the LTSS as they may need to do on the Medicaid, on the health side, and then also working with the housing agencies themselves.

We also looked at the rates so for the first time period, given our target population, we're making an assumption that with this work eventually we will see a savings on the healthcare cost side. That being said, that comes with time and also with some initial investment. So, we incorporated that into our rate structures as well.

We're in the process of developing some guidance and guidelines around billing of services and provider enrollment, and how can a homeless services agency become a Medicaid provider, etc. So, we're still in the process of working through all that. Again, it's a lot more work than we were anticipating. Although by now, one would anticipate that we should be expecting that whatever it is that we're doing probably takes twice the time and effort than perhaps what we had thought at the start. Those are some of the things we're doing with the Medicaid managed care plan.

MELANIE BROWN: There is a question about how your states plan to continue building upon this work. *What do you see is next in your supportive housing efforts?*

KATE MCEVOY: In Connecticut I really see us on an iterative path. We have had the benefit of experience with our state-funded services with MFP. We were able to translate that into a budget proposal that covers supportive housing services under Medicaid. I really hope we can continue to amplify this work. As I said we chose a more narrowly defined initial target population. Hope we build that out to encompass more of the entire set of people who matched.

Also, there are a lot of important additional features that relate to rebalancing of LTSS, in particular how we look at repurposing a lot of the institutional settings such as nursing facilities that must remain part of our care continuum but for which there is less demand over time. So, looking at how some of those may be repurposed for other types of housing including assisted living or shared housing, so that's obviously a certain cohort in the population, people with disabilities and older adults. Looking at how we continue to maximize the use of tax credits for new development because we're a very costly state for housing. I imagine that's the case for Judy also. So how do we reduce the overall costliness of it and do this in a way that helps support the sustainability, so those are some of my thoughts now.

JUDY MOHR PETERSON: It's hard for us to focus on hey, what's next, when we're in the process of trying to build on what we have. Our next steps are one, I'm trying to again increase and use the housing resources more efficiently and effectively. But the other area that has a lot of focus right now is actually on the continuum of care for behavioral health. This is for both mental health and substance use, and making sure we have a strong outpatient community in place that we're able to continue to provide the services so that we are able to address the full continuum. Because so many of our resources are going to the acute side and crisis services, all the way from primary care to those more mid-level treatment services that don't get quite as much attention. That is currently next steps and what we're focusing on in helping to address these issues.

MELANIE BROWN: *Which states or communities have been successful in using multiple data sources for supportive housing?* A number of resources have come out recently related to permanent supportive housing measuring as well as issues related to process. Some of those are available on the Assistant Secretary for Planning and Evaluation website. You can also reach out directly to us.

MELANIE STARNS: I'm still researching the previous question and I think we found the self-sufficiency piece on your slide, Kathy. (On answering the question), there are some reports that have been done in the past, I think the Corporation for Supportive Housing and the Center for Healthcare Services, have a number of reports and have worked with a lot of different states. So, we can see a number of reports from there, they would be another good source. Then some of the resources we'll add when we post the slides, will have some additional states.

KATHY MOSES: Just across even just our IAP states, a big piece of the data work is one, identifying the sources. Two, doing the work to put them together based on their needs. Obviously the most obvious two are Medicaid and HMIS, the homeless database, but also recidivism data if you're focusing on the formerly incarcerated population and looking at some of the behavioral health (data) to the degree you can

get your hands on that type of data. Sometimes it can be only a match between the two data sources, but a lot of times, especially as states get more and more tailored in terms of what they are trying to look at, they may be really interested in throwing in some additional data as well.

MELANIE STARNES: New York has done a lot of work in this arena and has looked at a lot of different data sources so those are a couple good states.

KATHY MOSES: New York, yes. Washington State has a really interesting prism. The data they used was developed in Washington State and they used that to match on all different markers as well. If you have a specific question for me send it to Melanie Starnes and she'll make sure to get it to me.

Conclusion

MELANIE BROWN: Thank you, panelists. We are out of time for questions. We will be sharing our contact information at the end. Also, please make use of our Medicaid.gov IAP webpage.

Some key takeaways from today's conversation were:

- Measuring the impact of supportive housing has significant benefits.
- Measuring the outcomes will require compiling data from a variety of sources.
- Supportive housing can affect more than just healthcare utilization costs.
- Measuring outcomes takes time. It's important not to allow perfection to be the enemy of good.

Slides will be made available on Medicaid.gov in about two weeks. Please complete the evaluation. [end of tape]