Optimizing Healthcare Coverage for Arkansas's Homeless Population

ACHI
Arkansas Center for Health Improvement

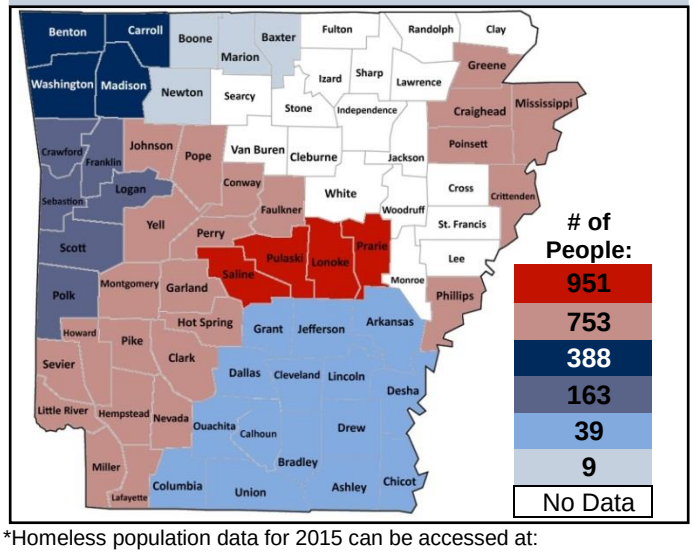
FACT SHEET • **DECEMBER 2015**

Until recently, Arkansas Medicaid has been largely restricted to children, pregnant woman, the aged, and the disabled. Arkansas's decision to extend coverage through the Health Care Independence Program (HCIP) to low-income adults provides the state with an opportunity to improve the health of its most vulnerable citizens, including the homeless. Homeless populations experience difficulty accessing medical care, treatment for mental health conditions, and care for substance use disorders, which can lead to high hospital utilization and costs, incarceration, and difficulty in obtaining housing. Studies show that reliable health care can result in overall cost reductions in caring for individuals who are homeless and can decrease homelessness.[2,3] This document provides information about Arkansas's homeless population, the advantages of healthcare coverage for them, and specific opportunities within Medicaid to provide services for individuals who are homeless.

HOMELESSNESS IN ARKANSAS*

- On **a single night** in Arkansas during January 2014:[4]
  - 2,936 total homeless (individuals and families)
  - **84.1 percent** unsheltered, chronically homeless individuals—**4th highest** among states in the nation
- **45 percent increase** in homeless veterans between 2009 and 2014[4]

Figure 1: Homeless Individuals by Region[4]



*Homeless population data for 2015 can be accessed at: https://www.hudexchange.info/resources/documents/2015-AHAR-Part-1.pdf

HOMELESSNESS AND HEALTH

Homelessness is a risk factor for poor health and has economic ramifications for people who are homeless and overall public cost if they remain uninsured or lack appropriate care.

In the United States:[2]

- 1 in 3 of all emergency department (ED) visits are made by homeless individuals
- The average cost for hospital admittance is $3700/stay
- About 80 percent of homeless ED visits are for preventable care
- The average homeless person will be admitted 5 times/year, costing approximately **$18,500/person/year**

In Arkansas in 2014:[4]

- 10 percent of homeless individuals have a severe mental illness
- 11 percent of homeless individuals are chronic substance users

The expanded opportunities for more affordable coverage in Arkansas offers an unprecedented opportunity to prevent unnecessary hospital visits, reduce healthcare costs, and provide behavioral health services for people that are experiencing homelessness.

HEALTH CARE FOR NEWLY ELIGIBLE HOMELESS

The Health Care Independence Program (HCIP) extended healthcare coverage to many of Arkansas's homeless population. Approximately 2,000 Arkansans were identified as homeless between October 2013 and January 2015 and were enrolled in newly available health coverage through the HCIP.[5] These beneficiaries and the healthcare providers who serve them can benefit from the new coverage. For example, in other states that have extended coverage to low-income adults, the newly insured homeless and their providers have reported the following:[1]

- **Homeless**: increased ability to work, reduced financial stress and medical debt, better access to mental health services and proper medication, and fewer trips to the ED
- **Providers**: more available treatment options, greater ability to offer a stable care plan over time, increased third-party payments and overall revenue resulting in increased staffing levels and operational improvements

Providing people who are homeless with relevant health care, understanding the cost savings benefits of doing so, and utilizing all resources available within Arkansas are all necessary to improve the health of this population while reducing overall spending related to homelessness.

ACHI is a nonpartisan, independent, health policy center that serves as a catalyst to improve the health of Arkansans.
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MEDICAID AND COST SAVINGS

Recent evidence illustrates the cost-effectiveness of related Medicaid expenses when housing-related services are available for people who are homeless—services that are not included in traditional Medicaid benefits. Housing-related services may include case management, personal care, psychosocial rehabilitation, adult day care health centers, and other relevant services. Table 1 below gives a brief overview of implemented programs and demonstrated results across the nation.

Table 1: Housing and Health Interventions for the Homeless

Organization	Program Description	Results
Chicago Housing for Health Partnership[3]	An intervention group of 200 homeless individuals receiving housing, mental health care, and case management services were compared to a control group receiving no services over the course of 18 months	Intervention group compared to control group: • 24 percent less ED visits • 29 percent fewer hospital admissions • Saved ~$25,000/person/year in Medicaid costs
California Frequent Users of Health Systems Initiative[2]	108 homeless California Medicaid enrollees received case management through Medicaid and access to housing through various grant funding in communities	• 27 percent reduction in hospital admissions and overall inpatient days • $39,000 reduction in Medicaid costs/person/year in hospital emergency and inpatient services
Seattle East Lake Project[6]	95 chronically homeless individuals with severe alcohol usage problems were provided housing and substance abuse treatment for 12 months	• Decreased total Medicaid expenses by 41 percent • Decreased alcohol usage by 30 percent

AVAILABLE MEDICAID OPPORTUNITIES

There are existing waivers and amendments available within Medicaid, such as Home and Community-Based Services (HCBS) waivers for states to provide housing-related services and meet the needs of people experiencing homelessness. Provided below are three Medicaid programs, as well as information regarding program eligibility, services offered, program utilization in Arkansas, and examples of how other states have implemented these Medicaid opportunities in order to provide services for the homeless in their state.[7,8]

HCBS-1915(c) Waiver[7,8]

Eligibility criteria: Individuals whose disability level meets eligibility requirement for institutional care

Services: Case management, personal care, adult day care health centers, home health aide, respite care, psychosocial rehabilitation

Arkansas: Currently uses the waiver to provide institutional care for adults with physical disabilities, autism, and the elderly

Louisiana: Within a permanent supportive housing unit, uses the waiver to provide case management, mental health and substance abuse treatment, developmental disability services, and care

HCBS-1915(i) State Plan Amendment[7,8]

Eligibility criteria: Individuals with physical and behavioral health issues who can maintain independence with the assistance of appropriate care

Services: Same as 1915(c) with option to request other services and create benefit package based on need

Arkansas: Had a waiver application pending state approval to integrate behavioral health services with Health Homes—on hold

Iowa: Operates a state-funded rental subsidy program that offers services and benefits through 1915(i) with costs from amendment being 50 percent federally subsidized

Health Homes[7,8]

Eligibility criteria: Individuals with a chronic health condition who are at risk for another, have two or more chronic conditions, or have a mental illness

Services: Integrate and coordinate primary and acute care, behavioral health, health promotion, patient and family support, referrals to community and support services

Arkansas: Previously planned to implement Health Homes in 2015—on hold

New York: Requires Health Homes to refer homeless patients to supportive housing providers in the Health Home's network

CONCLUSION

Arkansas is a leader in healthcare reform, and can continue to lead in the realm of health care for its citizens who are homeless. Evidence demonstrates the potential for individuals who are homeless to manage chronic health conditions, stay out of hospitals, and achieve housing stability with appropriate health care. Many homeless people in Arkansas face complicated environmental issues and moderate to severe mental illness and substance use disorders, signaling a need for services beyond traditional Medicaid. Medicaid does not allow allotment of funds for room and board, which is a basic need and a primary driver to improve the health and productivity of people who are homeless. Therefore, integration of public and private resources is needed to complement Medicaid and provide stable or transitioning housing. Coordinating housing resources along with taking advantage of Medicaid waivers and amendments to assist this vulnerable population could potentially mitigate the cyclical relationship of poor health and homelessness in Arkansas.

Additional Resources
(click for link)

- Coverage of Housing-Related Services for Individuals with Disabilities[a]
- State Strategies to Improve Health Through Housing Services[b]
- State Actions: Medicaid and Housing[c]
- The Business Case for Ending Homelessness: Having a Home Improves Health, Reduces Healthcare Utilization and Costs[d]

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[a] http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-06-26-2015.pdf

[b] https://www.statereforum.org/health-housing

[c] http://www.csh.org/2015/06/new-medicaid-resources-from-csh-focus-on-state-efforts/

[d] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4046466/