CHCF Issue Brief

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A Home and Healing:
How Medicaid Improves Health and Lowers Costs Among Members Experiencing Homelessness

Introduction

Over recent years, numerous states have implemented Medicaid initiatives aimed at enhancing health outcomes and controlling costs among the growing subset of members with complex health conditions who experience homelessness. Evidence demonstrates that interventions pairing care management with housing assistance not only improve health outcomes but also reduce costs. Consequently, these states have started covering services under Medicaid that help unhoused members connect to housing, yielding promising results. Without these services, states' ability to effectively meet the health and needs of these members is limited and will result in deteriorating health, premature mortality, and rising health care costs. This paper explores the reasons and methods behind state Medicaid programs' efforts to improve health and reduce costs for homeless members and how those efforts increase quality of care and affordability for the Medicaid program.

Ronald's Story

By the time he was referred to the Illumination Foundation in December 2022, a provider of housing and health services for people experiencing homelessness, Ronald had been experiencing homelessness across California's Orange County for more than a year.[1] He had had five emergency department visits and hospital admissions in the last six months alone due to complications related to diabetes mellitus. At each visit, the hospitals could do little more than help stabilize Ronald's acute symptoms. What Ronald really needed was a stable home so that he could engage in regular insulin therapy, have better nutrition, monitor his blood sugar, and rest.

If Ronald had been referred to Illumination a few years ago, he likely would have been referred to an emergency shelter, where he would remain on a years-long waiting list for housing assistance. While homeless, Ronald would inevitably continue to experience complications from his diabetes and other conditions like lower back pain. He would have continued to use the emergency department, require hospital admissions, and experience worsening health. People experiencing homelessness with chronic conditions like Ronald tend to die 20 years earlier than someone with the same condition who is stably housed.[2]

Fortunately, Ronald has had a different experience. That's because California is one of several states pursuing Medicaid initiatives helping Medicaid enrollees like Ronald address their health needs by attending to their housing needs. Through its CalAIM (California Advancing and Innovating Medi-Cal) initiative, California's Medicaid program, known as Medi-Cal, is covering a range of services and supports (PDF) to help eligible members experiencing homelessness find and maintain stable housing, connect to care and treatment, and avoid emergency departments and hospitalizations. These services include:

- **Enhanced Care Management** — comprehensive care management and coordination for eligible members with complex needs

- **Housing Transition Navigation Services** — assistance with finding, applying for, and obtaining housing, based on an individualized assessment of needs
- **Housing Tenancy Sustaining Services** — assistance to help members maintain stable tenancy including assistance with independent living skills, understanding and complying with lease terms, ensuring health and safety, crisis intervention, and conflict resolution
- **Recuperative Care (also called Medical Respite)** — a short-term residential setting providing ongoing monitoring for a medical or behavioral health condition for members experiencing homelessness and recovering from an injury or illness
- **Short-Term Post-Hospitalization Housing** — provides members exiting an institution and experiencing or at risk of homelessness with a short-term residential setting to continue their medical/psychiatric/substance use disorder recovery immediately after exiting the institution
- **Day Habilitation** — services provided in a home or other community-based setting that help members acquire, retain, and improve self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment
- **Housing Deposits** — help with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household
- **Transitional Rent** — provides up to six months' assistance with rent for people experiencing or at risk of homelessness and exiting institutional care, as a means of facilitating transition to permanent housing[3]

Because of CalAIM:

- Ronald was admitted to Illumination Foundation's Recuperative Care program.
- While there, Ronald was referred to and approved to receive Housing Transition Navigation Services.
- Because of a data sharing agreement between the Orange County Healthcare Agency and his Medi-Cal managed care plan, Ronald's housing navigator learned that his medical needs and history qualified him as a person with a disability.
- Ronald's housing navigator helped him to apply for and obtain a Mainstream Voucher, a US Department of Housing and Urban Development rental subsidy for people with disabilities.
- While working with his housing navigator to search for an apartment, Ronald participated in a Day Habilitation program to obtain independent living skills and learn how to manage his housing and finances as well as self-manage his diabetes.
- With the assistance of his housing navigator, Ronald found an apartment. Before the lease signing, Ronald's housing navigator was able to cover the security deposit through Housing Deposits.
- In July 2023, Ronald moved into his own unit and was referred to Housing Tenancy Sustaining Services, which worked with him on a number of goals, including obtaining Supplemental Security Income benefits.
- Ronald continues to remain connected to care management through the community health center, has remained in his housing, and has not returned to the emergency department since.

Homelessness Is a Driver of Poor Health and Higher Health Care Costs; Housing and Care Management Can Improve Both

Ronald's story puts a face on several points well documented in the research literature:

- ***Harm:*** *Homelessness contributes to poor health and premature mortality.* A national study of the health needs of people experiencing homelessness found that 73% of people experiencing homelessness had at least one unmet health need, 46% had two or more chronic medical comorbidities, and nearly 48% had a history of mental illness.[4] These unmet health needs — exacerbated by exposure to harsh conditions, environmental hazards, and interpersonal violence as a result of lacking a stable home — have life-and-death consequences. People experiencing homelessness face a mortality risk 3.5 times higher than people with similar conditions who have housing.[5] In addition, research shows that homeless adults experience accelerated aging, with premature onset of chronic medical conditions and cognitive and functional impairment.[6]
- ***Utilization:*** *Homelessness prevents the treatment of health conditions, leading to an overuse of emergency care.* Studies have shown how persistent homelessness and the lack of stable housing prevents the effective treatment of chronic health conditions and disease, as well as recovery from behavioral health conditions like mental illnesses and substance use.[7] Homelessness and lack of stable housing leads to an overuse of emergency and inpatient hospital admissions, as well as high rates of avoidable hospital readmission.[8] Despite the utilization of acute care services, homeless people report unmet health care needs. For example, although people experiencing homelessness use psychiatric inpatient hospitalizations and substance use treatment services, they fail to recover due the stress and instability encountered while experiencing homelessness.[9]
- ***Affordability:*** *Homelessness drives higher health costs.* Numerous studies show that overreliance on acute and emergency health services among people experiencing homelessness leads to higher health care expenditures. For example, a statewide study in New Jersey found that health care expenditures for people experiencing homelessness were 10% to 27% higher than matched housed counterparts, while another study found that people experiencing homelessness had health care expenditures 2.5 times higher than comparable housed populations.[10]

Ronald's story also helps to illustrate that covering targeted interventions that address the housing needs of members experiencing homelessness can improve the effectiveness of health care and treatment, shift utilization patterns toward more appropriate kinds of care, improve health, and lower costs. These impacts have also been well documented through research:

- **Interventions that coordinate care management with housing assistance improve treatment outcomes and health outcomes.** Numerous studies have found that interventions that combine care management with housing assistance can increase participation in appropriate treatment, improve medication adherence, improve health outcomes, and reduce mortality risk.[11]
- **Medical respite and recuperative care programs shorten hospital stays and reduce readmissions.** A study of medical respite programs found that, by shortening hospital stays and reducing subsequent acute care episodes, these programs could save approximately $2,000–3,000 per hospitalization for a person experiencing homelessness.[12]

State Medicaid Initiatives Improve Health and Lower Costs Through Addressing Homeless Members' Housing Needs

Given these findings, it is no surprise that in addition to California, several other states have been focused on providing services under Medicaid that help address homelessness among high-need, high-cost members. Medicaid initiatives focused on improving the health of homeless and unstably housed members are happening in more than a dozen states across the country.[13] Examples include the following:

- **Arizona Health and Housing Opportunities (H2O) Program.** After seeing promising results (PDF) in improved health and lower health care costs from prior state-funded permanent supportive housing programs, the Arizona Health Care Cost Containment System, Arizona's Medicaid agency, officially launched its H2O Program in October 2024.[14] H2O is implemented as part of AHCCCS' Medicaid Section 1115 waiver and involves coordinating federal housing vouchers with Medicaid-funded "pre-tenancy and tenancy sustaining services" (housing navigation and home-based case management) alongside transitional housing, move-in assistance, and short-term rental assistance, to improve health and lower Medicaid costs among people with serious mental illness experiencing homelessness, justice system involvement, or both.[15]
- **Louisiana Department of Health Permanent Supportive Housing.** In the aftermath of hurricanes Katrina and Rita, the Louisiana Department of Health and Louisiana Housing Corporation coordinated to provide over 3,000 units of permanent supportive housing for homeless Medicaid members with disabilities. The housing was provided by pairing individualized care management and tenancy supports funded through Section 1915i Home and Community Based Services and other federal and state programs, with federal Housing Choice Vouchers and units within affordable housing projects subsidized by Low Income Housing Tax Credits. Since inception, the program has served more than 9,000 people with disabilities and complex care needs to exit homelessness and avoid institutional care settings.[16]
- **Maryland Assistance in Community Integration Services Pilot and Program.** Beginning in 2017, the Maryland Department of Health received approval from the Centers for Medicare & Medicaid Services to administer a pilot program for members with complex health needs who are experiencing homelessness or housing insecurity. This pilot, under the authority of Maryland's Section 1115 HealthChoice Waiver, provides qualifying members with intensive supportive services like housing tenancy support, case management, peer support, and financial management, and coordinates these services with federal and state housing vouchers and programs. Initially implemented in four counties, the Maryland Department of Health is now working to expand Assistance in Community Integration Services statewide.[17]
- **Massachusetts Community Support Program for Homeless Individuals and other housing services.** Under its Section 1115 waiver, MassHealth, Massachusetts' Medicaid agency, has been implementing Community Support Program for Homeless Individuals (CSP-HI) (PDF), which provides pre-tenancy supports, support in transitioning into housing, and tenancy sustaining supports to Medicaid enrollees who are experiencing homelessness and who have chronic health conditions. CSP-HI was based on a prior program, Community Supports for People Experiencing Chronic Homelessness, which a study found reduced health care costs by $11,914 per person, resulting in a net annual per person savings of over $7,000.[18]

- **Montana Healing and Ending Addiction Through Recovery and Treatment Demonstration's Pre-Tenancy and Tenancy Support Services.** As part of its Medicaid Section 1115 demonstration, Montana has received approval to cover pre-tenancy and tenancy support services to help members with behavioral health needs who are experiencing homelessness or frequent housing instability. To qualify, they must have had frequent or lengthy stays in an institutional or residential setting, frequent emergency department visits or hospitalizations, a history of incarceration, or a loss of housing as a result of behavioral health symptoms. These services are scheduled for implementation later this year.[19]
- **North Carolina's Healthy Opportunities Pilots.** Implemented in three mostly rural regions of the state, North Carolina's Healthy Opportunities Pilots is a Section 1115 Medicaid demonstration to test and evaluate the impact of providing select interventions that meet housing, food, transportation, and interpersonal safety needs and counter toxic stress in order to improve health care access and outcomes among high-need Medicaid enrollees. Providers under the Healthy Opportunities Pilots assisted Medicaid members to resolve homelessness and housing challenges as a means of facilitating better health care access and effectiveness.[20]

In addition to these initiatives, two states — Kentucky (PDF) and Utah (PDF) — recently approved coverage of medical respite programs as Medicaid services.[21]

Although they vary somewhat in terms of the types of services covered, these state initiatives share several things in common:

- **The goal is to improve health care and health outcomes while lowering costs o**f providing care to homeless members. These state initiatives are based on the recognition that a subset of Medicaid members continue to experience poor health outcomes while driving higher spending because of their lack of stable housing. The initiatives' goal is to help these members connect to stable housing in order to make health care and treatment more effective, thereby improving health outcomes while lowering costs.
- **They all keep Medicaid's role focused on housing services, and leverage partnerships with the housing sector for housing.** In all these examples, states are covering housing-related services such as case management to help people conduct housing searches and gain habilitation skills in housing, modify homes to accommodate disabilities and medical needs, and facilitate transitions to housing. In all cases, the housing assistance itself, such as subsidized housing or long-term rent subsidies, is provided through partnerships with the housing sector and federal and state housing programs. Although a few states are covering short-term rental assistance under Medicaid, it is limited to a lifetime maximum of six months per member, and the goal of this service is to bridge to long-term rent subsidies funded by the US Department of Housing and Urban Development or other state housing programs. In other words, Medicaid is covering supportive services to help connect people to housing, not the long-term housing costs themselves.
- **They are based on long-standing Medicaid authorities to cover housing-related services.** Although Medicaid's coverage of housing-related services may seem groundbreaking, services that help people navigate to housing, transition to housing, retain their tenancy, and make homes accommodating to disabilities and medical needs have all been Medicaid services — under Home and Community Based Services (HCBS) waivers — for over four decades.[22] HCBS were originally authorized as a way to help people with disabilities exit and avoid institutional care. However, existing Section 1915(c) waivers are limited to people who are transitioning out of long-term care settings or who meet narrow criteria for institutional care. State Medicaid initiatives focused on homelessness are

essentially providing HCBS-like services slightly "upstream" — for members likely to need an institutional level of care in the future without intervention, or people currently experiencing long-term institutionalization but instead are in and out of hospitals and other inpatient facilities.

Even though these efforts are still in their early stages, they are already showing results:

- An evaluation of California's Whole Person Care pilot (PDF) — the precursor to CalAIM — found that the provision of care coordination and housing supports for people experiencing homelessness reduced emergency department visits and inpatient hospitalizations and increased utilization of mental health and substance use disorder treatment. The pilots resulted in a net decrease in total Medicaid costs over the five-year pilot period.[23]
- An evaluation of North Carolina's Healthy Opportunities Pilot (PDF) found that members decreased emergency department visits and inpatient hospitalizations and was associated with an $85 per person per month reduction in total Medicaid costs.[24]
- A preliminary evaluation of Maryland's Assistance in Community Integration Services program found a 48% reduction in hospital visits and a 51% reduction in emergency department visits among members who received the intervention.[25]

These early results suggest that these state initiatives hold the promise of achieving Medicaid's "holy grail" of improving health care while lowering costs among at least a subset of high-need, high-cost members. With more time for implementation and more states pursuing these initiatives, much more can be learned about how to tailor health care to people with complex health needs.

Reduction in Medicaid Supports for Homeless Members Could Set States Back in Improving Their Health

These state Medicaid initiatives focused on members experiencing homelessness now face uncertainty. For example, the Trump administration has withdrawn some Biden-era guidance on Medicaid's coverage of services that address health-related social needs.[26] Federal policymakers should take care not to set states back on their promising work to improve health while lowering costs among their members. This is for a few reasons:

- **Homelessness among Medicaid members is increasing.** With the number of people experiencing homelessness in the United States at an all-time high and rising and with improved Medicaid enrollment among people experiencing homelessness, more Medicaid enrollees are experiencing homelessness than ever. Moreover, changes to federal housing assistance could drive further increases in homelessness.
- **Homelessness among members will drive higher Medicaid costs for states.** Left unaddressed, homelessness among Medicaid members will lead to higher use of emergency departments, inpatient hospitalizations, and other more costly acute care services — services that states are required to pay for. Rising homelessness among members translates into rising Medicaid costs for state and federal payers.
- **Federal policy changes could prevent states from controlling costs and improving care.** Federal decisionmakers should consider the impacts of any future recissions or denials of state Medicaid waivers that cover housing-related services. Such actions could prevent states from pursuing the kinds of initiatives and approaches that would enable them to

improve health and lower costs among members experiencing homelessness, namely, providing the care management and housing supports that helps members obtain a stable home so they can obtain more appropriate treatment and care and avoid emergency department visits and hospitalizations.

In short, federal decisionmakers should consider the effects of limiting these types of programs. It could exacerbate homelessness, enable inappropriate health care utilization, and increase costs to the health system. It could also undermine states' ability to address members' health needs, leading to poor health and premature mortality. State initiatives that improve health outcomes and reduce costs should be supported, rather than hindered.

About the Author

Richard Cho, PhD, managing director, Manatt Health Strategies, helps clients improve housing and health outcomes for older adults, people with disabilities, and people experiencing homelessness. He previously worked at the US Department of Housing and Urban Development, the US Interagency Council on Homelessness, the Connecticut Coalition to End Homelessness, and the Corporation for Supportive Housing.

About the Foundation

The **California Health Care Foundation** (CHCF) is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.Endnotes

Endnotes

1. "Ronald" is a real person whose name has been changed to protect his privacy.
2. Bruce D. Meyer et al., "Life and Death at the Margins of Society: The Mortality of the U.S. Homeless Population," National Bureau of Economic Research, working paper 31843, November 2023.
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17. For more details, see "Assistance in Community Integration Services Pilot," Maryland Medicaid Administration.
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