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How Medicaid and States Could Better Meet Health Needs of Persons Experiencing Homelessness

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Abstract

An estimated 580 000 people experienced homelessness on any single night in the United States in 2020. This article argues that, to address these persons' unmet needs, Medicaid should collaborate with clinicians and state programs to provide permanent supportive housing and housing support services to individuals experiencing homelessness. Access to shelter can improve health outcomes for individuals experiencing homelessness and reduce overall health care costs.

Housing and Health

The US Department of Housing and Urban Development defines homelessness as an individual or family lacking a fixed, regular, and adequate nighttime residence.[1] Although homelessness decreased in the United States by 12% from 2007 to 2019,[2] in 2020, an estimated 580 000 individuals still experienced homelessness on any given night.[3] Most (61%) stayed in sheltered locations, while others (39%) remained unsheltered (eg, lived under bridges or in cars).[3] In January 2020, roughly 25% of individuals experiencing homelessness (110 528 people) had "chronic patterns of homelessness," experiencing homelessness continually for a year or more or experiencing at least 4 episodes of homelessness during the last 3 years.[3]

People experiencing homelessness have unmet health needs. On a given night in January 2010, 26% of sheltered persons experiencing homelessness had a severe mental illness and 35% had problems with substance use.[4] More generally, homelessness is associated with poor health outcomes (eg, shorter life expectancy, higher usage of acute hospital services, and higher mortality and morbidity).[5,6] An estimated 80% of emergency department visits made by individuals experiencing homelessness are for preventable illnesses that could be far more efficiently and effectively managed from both cost and health perspectives.[7]

Medicaid Expansion

The COVID-19 pandemic has exacerbated the US homelessness crisis. In 2020, homelessness increased by 2% over 2019.[3] Millions of Americans, especially those with low incomes, have lost employment or are working reduced hours due to the pandemic; many are at risk of eviction when state moratoriums expire now that the federal

moratorium has expired.[8] Given homelessness' association with costly care and poor outcomes, clinicians, organizations, insurers, and other health sector stakeholders have ethical responsibilities to motivate Medicaid expansion.

Under the Patient Protection and Affordable Care Act of 2010, 38 states and the District of Columbia adopted Medicaid expansion and increased health insurance coverage to individuals with annual incomes at or below 138% of the federal poverty level.[9] This law also increased health care coverage among individuals experiencing homelessness: individuals experiencing homelessness with Medicaid coverage jumped from 45% in 2012 to 67% in 2014 in states that expanded Medicaid and only increased from 26% in 2012 to 30% in 2014 in states that did not.[10] For newly covered individuals experiencing homelessness, Medicaid expansion delivered a pathway to secure needed health services.[11]

Medicaid Expansion and Housing

Because Medicaid can cover certain-housing related services, Medicaid expansion can also increase access to housing support services and permanent supportive housing and help recipients secure employment and income.[12,13] Permanent supportive housing is an effective intervention for improving health outcomes for individuals experiencing chronic homelessness and for decreasing overall health care costs,[13,14,15] since it provides long-term affordable housing and needed services (eg, employment assistance, mental illness treatment, and substance use disorders treatment interventions).[15] A study in Oregon reported a 55% reduction in Medicaid costs 1 year after individuals experiencing homelessness received permanent supportive housing.[16] Another study in Chicago found that providing transitional and long-term housing to individuals experiencing homelessness led to a 29% reduction in hospital days and a 24% reduction in emergency department visits.[17] Similarly, a program in New York State that provided 2300 supportive housing units and housing support services for individuals experiencing chronic homelessness[18] reduced the average number of inpatient days and emergency department visits over a 12-month period.[19] The program also reduced average Medicaid costs by $9526 per person over a 2-year period.[20]

Yet health insurance under Medicaid is not enough to meet the health needs of individuals experiencing homelessness. The high burden of chronic disease and disability among individuals experiencing homelessness, as well as lack of stable housing that can limit access to healthy foods and make it difficult to adhere to recommended interventions, is a significant obstacle for members of this population and those who care for them.[21]

Given Medicaid's provision of health insurance to many individuals experiencing homelessness, state Medicaid programs have incentives to provide housing-related services and collaborate with supportive housing programs to improve health outcomes and decrease costs of care for this population. In 2015, the Centers for Medicare and Medicaid Services released an informational bulletin stating that, under 1915(c) home and community-based service waivers, Medicaid funds can be used to help individuals prepare for and transition to housing, help identify and secure housing options, and provide services to help individuals be successful tenants.[22] Medicaid funds can also support behavioral health and substance use interventions[22] and some transportation expenses.[23]

State Laboratories

Some states, such as Oregon and Louisiana, have waivers to support Medicaid beneficiaries with housing services, such as search assistance, eviction prevention, and care coordination among clinicians in primary care, mental health, and dentistry.[12,24] For example, in 2005, the Louisiana Department of Health and the Louisiana Housing Authority created the Permanent Supportive Housing Program in response to hurricanes Katrina and Rita.[12] Housing was funded through federal low-income housing credits and disaster recovery funding. Most individuals and families supported by these programs were Medicaid beneficiaries, so Louisiana used Medicaid funds to cover some of these individuals' and families' costs of pre-tenancy, move-in, and ongoing tenancy services. Since its initiation in 2008, the program has had a 94% retention rate and led to a 24% reduction in average monthly Medicaid costs per person that demonstrates the key health benefits to individuals and families whose Medicaid benefits were applied to cover tenancy support services.[12,25] Hawaii also gained approval to use Medicaid funds for housing services,[26] and it introduced a bill that would classify chronic homelessness as a key health determinant to direct some state Medicaid funds to secure beneficiaries' housing.[27] Research on such initiatives can continue to motivate better understanding of the health benefits of applying insurance benefits to housing services.

Clinicians' and Organizations' Roles

Medicaid can't resolve homelessness alone. Clinicians, like members of the general public, hold implicit or unconscious biases about socially stigmatized groups, including individuals experiencing homelessness. Since bias can influence diagnoses and intervention recommendations and exacerbate inequity,[28,29,30] clinicians and students must first be trained to identify and mitigate its influence on clinical and ethical decision making. Second, clinicians should see clinical encounters with patients as opportunities to assess and address social determinants of their patients' health. Only 24% of hospitals and 16% of physician practices nationwide reported screening patients for basic health security (eg, food access, housing instability, and exposure to violence).[31] Such health information is needed to understand patients' health risks; to contextualize their capacity to adhere to health recommendations; to modify interventions to be helpful, useful, and responsive to patient vulnerabilities; and to facilitate patients' connections with resources (eg, shelters, community centers, food pantries, and state and federal welfare programs).[32,33,34,35] Third, clinicians can direct individuals experiencing homelessness who qualify for Medicaid to enroll. One study of 725 adults experiencing chronic homelessness in 11 cities found that almost 75% of Medicaid-eligible individuals were not enrolled in the program.[11] State Medicaid programs can support clinicians' and organizations' efforts by incentivizing and standardizing relevant data collection and use to facilitate research about program quality in motivating health outcome improvements among persons experiencing heomelessness.[36]

State Medicaid programs should collaborate with key supportive housing programs to better leverage health care infrastructure to serve people with complex clinical, behavioral, and social needs and to apply best practices to care of individuals experiencing homelessness.

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