

Exploring Financing Options for Services in Affordable Senior Housing Communities



About this Report

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The views expressed here, and the interpretation of statements made by interviewees and convening participants, are those of the authors and not the foundation.

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Introduction

A large and rapidly expanding population of older adults with low incomes faces the challenge of finding affordable, safe housing that can accommodate changing needs as they grow older. An increasing proportion of these older adults experience multiple chronic illnesses as they age. In many cases, deteriorating physical and cognitive functioning impede the ability of these older Americans to live independently in the community.

These personal challenges often translate into higher costs for public programs like Medicare and Medicaid, which are the primary payers of health care and long-term services and supports (LTSS) in the United States. With the rapid aging of the population over the next 20 years, these challenges—and their impact on the social safety net—are expected to grow.

Recent research suggests a potential solution: Models using affordable senior housing as a platform for delivering health and supportive services can help older adults remain healthy and independent for longer, improve their quality of life, and reduce their utilization of costly health care services. Despite this growing evidence base, however, there is a pressing, and unresolved, need for sustainable financing options to support these housing plus services models.¹

Staff from the LeadingAge LTSS Center @UMass Boston, the National Well Home Network, and the Harvard Medical School Department of Health Care Policy conducted a yearlong exploration of potential financing options to support housing plus services models. The exploration entailed a literature review and interviews conducted with multiple expert stakeholders, including representatives of managed care organizations and accountable care organizations (ACO), Medicare and Medicaid policy experts, federal and state health policy officials, health care providers, and affordable housing providers.

The project was supported by the Gordon and Betty Moore Foundation.

THIS PAPER:

- Describes the housing plus services model considered in this exploration, and the benefits associated with this model.
- Defines criteria for considering potential financing sources.
- Considers features of the housing plus services model that would be supported by potential financial sources.
- Examines key issues that may bear on the feasibility of potential financing mechanisms for housing plus services models.
- Discusses aspects of the Medicare and Medicaid programs that may facilitate or inhibit possible financial support of the model.
- Presents and evaluates potential financing solutions that could make the housing plus services model feasible and sustainable.

A draft of this paper was reviewed and discussed during an April 2018 convening, held in Washington, DC, and attended by many of the stakeholders who participated in the original interviews. A list of the interviewed experts and convening participants can be found in Appendix A.

The Housing Plus Services Model

The housing plus services model considered in this exploration is currently being tested in a three-year, randomized control trial implemented by the U.S. Department of Housing and Urban Development (HUD) in 40 sites across the country. The model's design is based on previous explorations of promising housing-based services models.

Model Features

Key components of the housing plus services model include its delivery location in housing communities, its onsite interdisciplinary team, and its package of services.

Delivery Location: The housing plus services model is set in independent, affordable senior housing communities that receive government assistance to make rents affordable to older adults with lower incomes. This assistance could come from HUD, Low-Income Housing Tax Credits (LIHTC), U.S. Department of Agriculture Rural Development, and/or state/local funding.

The housing communities hosting the model are not licensed as assisted living or residential care. Residents live in their own apartments, maintain a landlord/tenant relationship with the property, and are protected by fair housing statutes.

Staffing: An interdisciplinary team delivers on-site services at the housing property and helps residents connect with services and resources in the community. That team includes:

- ➔ A *full-time service coordinator* who fills a role that is similar to a social worker.
- ➔ A *wellness nurse* who is at the property for 20 hours per week. The wellness nurse does not provide skilled nursing care.

Services: Use of all services is voluntary and based on resident need. Services include:

- ➔ *Assessment* of social, health, and functional circumstances and needs. A formal assessment is conducted annually, with regular informal assessments taking place as housing staff engage with and observe residents.
- ➔ *Service Coordination*, which may include:
 - Helping residents identify, apply for, and maintain benefits such as Medicare and Medicaid, utility assistance, telephone assistance, or Supplemental Nutrition Assistance Program (SNAP).
 - Helping to arrange transportation for residents.
 - Supporting access to food/nutrition by connecting residents with food banks offering on-site distribution or delivery of food or meals.
 - Acting as a liaison with residents' health and/or social service providers.
 - Helping residents resolve hoarding, lease violation, and other issues that could put their housing at risk.

- ➔ *Wellness/prevention interventions*, including:
 - Health education and coaching.
 - Vital sign monitoring.
 - Medication review/reconciliation and help accessing medication management assistance. The on-site team does not administer medications, provide regular medication reminders, or fill pill boxes.
 - Support in obtaining vaccinations through on-site clinics or referrals to community options.
 - On-site wellness programming in such areas as chronic disease management, fitness, and nutrition. Programming may be conducted by the onsite team or through community organizations.
 - On-site activities to help combat isolation and loneliness.
- ➔ *Transitional care monitoring/assistance*, through which the on-site team helps residents transition successfully to home after a stay in a hospital or rehabilitation setting. This assistance may involve helping residents schedule follow-up medical appointments, understand discharge instructions, fill new prescriptions, reconcile medications, or utilize other needed services. If an external transition program is in place, the team will support that effort and fill gaps.

Guiding Principles

The housing plus services model is based in senior housing, takes a population health approach, and is focused on older adults with low incomes.

- ➔ **Place-based:** Operating within an affordable senior housing community allows the housing plus services model to achieve an economy of scale by providing services to large numbers of people who live in physical proximity to one another. The model also provides an opportunity for the on-site team to build relationships with residents of the housing community and observe individuals in their homes on a regular basis.²
- ➔ **Population health approach:** The housing plus services model serves all residents in the housing community, not just those who are frail, high-risk, or high utilizers of health services. Residents receive varying levels of assistance based **on current or changing needs**.
- ➔ **Focus on older adults:** The housing plus services model is delivered in housing communities that have a large concentration of older adults. The model also recognizes and supports senior housing community residents who are younger persons with disabilities.
- ➔ **Focus on individuals with low incomes:** The housing plus services model focuses on a lower income population that is at higher risk for poor health outcomes and has greater challenges accessing or purchasing the assistance or support needed to better address health, functional, and social care needs.

Advantages and Outcomes of Housing Plus Services Models

Various reform efforts at the federal and state levels have created a range of goals and incentives that encourage health and LTSS providers and payers, including insurers and managed care organizations, to improve health outcomes, enhance the care experience, and lower costs. An expanding number of value-based approaches connect payment for services to desirable outcomes, not just the provision of a service. Additional efforts have focused on supporting individuals with physical or functional challenges so they can live in the most independent setting possible and avoid unnecessary movement to higher levels of care.

The housing plus services model could assist providers and payers in achieving many of these policy and practice goals. In addition, housing plus services models hold multiple benefits and lead to positive outcomes for residents, the providers serving them, and the public payers supporting the services they utilize.

Advantages

Housing plus services models offers several potential advantages:

- ➔ **A targeted population:** The model reaches a concentration of at-risk individuals, including individuals who are dually eligible for Medicare and Medicaid.
- ➔ **Delivery efficiencies:** The model leverages existing staff and infrastructure resources available in the housing community. It also gives providers the opportunity to have direct and regular contact with multiple people in one place. This minimizes both travel time for providers and access limitations for older adults.
- ➔ **Strong relationships:** Housing-based staff develop trusting relationships with residents; get to know their preferences, needs, and capacities; remind and encourage residents to participate in activities and appointments; notice potential emerging health issues before they become crises; and identify and help residents overcome barriers that may be preventing them from following through on appointments and needed self-care management.

Evidence-based Outcomes

Evidence documenting the benefits of the housing plus services model is growing. Some studies have examined models that incorporate a service coordinator/social worker and wellness nurse team similar to the one explored in this paper. Other studies have evaluated models that incorporate a service coordinator and other on-site services.

Several studies associate housing plus service models with:

- ➔ **Lower hospital usage:** One study found that residents in housing communities with an on-site service coordinator were 18% less likely to have a hospital stay during the year. A study examining six affordable senior housing communities offering the Selfhelp Active Services for Aging Model in Queens, NY, found that residents had hospital discharge rates that were 32% lower and hospital lengths of stay that were one day shorter compared to other Medicare beneficiaries in the same zip code.⁴ Another evaluation found that older adults with multiple chronic conditions residing in senior housing were less likely to be hospitalized over time than those residing in other housing settings.⁵

Advantages and Outcomes of Housing Plus Services Models

- ➔ **Lower Medicare expenditure growth:** Participants in urban panels of the Support and Services at Home (SASH) program in Vermont experienced a slower growth in annual total Medicare expenditures of \$1,467 compared to beneficiaries in a comparison group. These outcomes were driven by slower growth in expenditures for hospital care, emergency department (ED) visits, and specialist physician visits.⁶
- ➔ **Higher value health care usage:** Participants in the Staying at Home program in Pittsburgh, PA, were significantly more likely to visit the dentist, use health care services outside a hospital (e.g., primary care), and report health improvements.⁷ Conversely, participants were significantly less likely to visit the ED, have unscheduled hospital stays, and report negative health outcomes. Another study found residents who engaged with the Housing with Services initiative in Portland, OR, were more likely to use preventative health and outpatient mental health services.⁸
- ➔ **Success reaching high-risk populations:** The evaluation of the Portland Housing with Services initiative also found the program was able to reach residents with prior high use of hospitals and/or EDs.
- ➔ **Fewer nursing home transfers:** Limited research has been conducted on the impact of the housing plus services model on Medicaid and LTSS services for the 65+ population. However, the study of Pittsburgh's Staying at Home program found participants were less likely to move to a nursing home than non-participants.

What Elements of the Model Would be Funded?

Ideally, the complete service component of the housing plus services model would be paid for through the chosen funding mechanism. This service component would include staffing, programming, and model-related administrative costs.

Potentially, the financing source or payer would be able to leverage existing funding for the service-coordinator role, which is the only model component that currently receives any level of sustainable funding. In HUD- or LIHTC-supported properties, the service coordinator may be supported through a housing community's operating budget. HUD also provides grants that are generally and reliably available for the position over an extended term.

Specific activities and components that potentially would require funding include:

- ➔ **Staffing:** Although the service coordinator position currently receives some level of reliable government funding, that funding is not adequate and would need to be augmented to support the position at the desired staff-to-resident ratio. HUD-supported service coordinators are only available in approximately 40% of eligible communities serving older adults or persons with disabilities. Service coordinators' hourly presence and caseloads can vary within these housing communities. LIHTC properties are also allowed to support service coordinators in their operating budgets. When available, however, this support generally tends to be for a limited number of hours. The wellness nurse position is currently not supported in any type of assisted housing. Where a wellness nurse is present, the position is generally covered through grants or in-kind partnerships and for a limited number of hours.
- ➔ **Programming:** Staff would provide or coordinate programming such as evidenced-based health and wellness programs (e.g. chronic-disease management or falls prevention), fitness programs, or other education sessions. Funding would be needed for associated program fees, trainers, and supplies.
- ➔ **Administrative expenses:** This component would include items such as expenses for a database/data collection infrastructure, management/oversight, and staff training. Housing communities currently receiving HUD funding for a service coordinator have some allowances in their budgets/grants related to these expenses.

Funding for the development or operation of the housing property would not be considered a target for financing, because the focus of this exploration is on the service-enrichment component of the model.

Potential Financing Sources

This exploration established a set of criteria for evaluating the efficacy of potential financing mechanisms and then determined which options met these criteria.

Financing Source Criteria

Four criteria for a potential financing mechanism were established, including:

1. **Source already exists:** This exploration did not consider the possibility of creating a new funding source for housing plus service models. Rather, its goal was to take advantage of funding sources that already exist.
2. **Sustainability:** The funding sources should have a reasonable certainty of being available over time. Intermittent or unpredictable funding sources, such as grants, community benefit dollars, or other charitable sources, were not considered.
3. **Have broad eligibility and scalability:** Large portions of residents in a senior housing community should be eligible for coverage and the funding sources should be generally available across geographies. Benefits with limited scale, such as Older Americans Act funds or unique state or local funding sources, were not considered.
4. **Benefits will accrue to the funding source:** Potentially, funding sources would be impacted by and/or benefit from the housing plus services model.

Funding Sources Considered

Given the criteria listed above, this exploration focused on Medicare and Medicaid as the most viable funding sources for housing plus services models. With a few exceptions, most residents of affordable senior housing communities are eligible for Medicare.² In addition, many residents are also dually eligible for Medicaid. *Figure 1* shows the percentage of residents in HUD-assisted housing communities who are Medicare and/or Medicaid beneficiaries.

Figure 1: Individuals in HUD-assisted Housing Who Match to Medicare and/or Medicaid

Insurance Status	Residents Under Age 65	Residents Age 65 and Over
Medicaid only	62.5%	2.3%
Medicare only	1.1%	27.3%
Medicaid & Medicare	5.5%	57.8%

Source: The Lewin Group. (2014). *Picture of housing and health: Medicare and Medicaid use among older adults in HUD-assisted housing*. Washington, DC: U.S. Department of Health and Human Services. Available at: <http://aspe.hhs.gov/daltcp/reports/2014/HUDpic.shtml>.

As entitlements, Medicare and Medicaid are broadly available in all communities to those who meet the eligibility criteria. Additionally, research discussed above shows that housing plus services models positively affect health care utilization and expenditures that are paid for by Medicare and Medicaid.

Key Issues

Several issues influence the feasibility of housing plus services financing options.

Volume

A major concern for housing plus services financing mechanisms is the volume of consumers that would be covered by a payer entity. This volume is driven by the number of residents living in housing communities and the diversity of resident insurance coverage arrangements.

- ➔ **Resident population:** Housing communities vary in size and could range from as small as 20 apartments to as large as 200+ apartments. Smaller housing communities would likely be unable to sustain full-time staff and would need to join with other housing communities in their geographic area to deliver housing-based services.
- ➔ **Insurance coverage:** Residents are often split across health insurance coverage and providers. Although most residents of a housing community are eligible for Medicare, they may receive Medicare coverage through different mechanisms, including fee for service (FFS), Medicare Advantage (MA) plans, Special Needs Plans (SNPs), and Medicare-Medicaid plans(MMPs). (See *Figure 2.*) In addition, residents enrolled in each of these Medicare options could be split across multiple primary care practices, ACOs, or health plan entities.

As mentioned, a large proportion of affordable senior housing residents are dually eligible for Medicare and Medicaid (see *Figure 1* above), but this eligibility can vary in different types of housing. For example, because residents in LIHTC properties generally tend to have higher incomes than many HUD-assisted housing residents, fewer LIHTC residents are eligible for Medicaid. Although Medicaid primarily covers LTSS for the older adult population, not all Medicaid-eligible residents need or use LTSS.

Figure 2: Sources of Medicare Coverage

Form of Medicare	General Medicare Population (2017)	HUD-assisted Population 65+ (2008)
Fee for Service	68%	62%
Medicare Advantage	32%	38%
Special Needs Plans	12% of MA	unknown
Medicare-Medicaid Plans ¹	unknown	unknown

¹ Currently available in 2 states; plans are not always statewide.
 Source: General population: [http://bettermedicarealliance.org/sites/default/files/2017-07/ Understanding%20 Risk%2AdjustmentJune2017.pdf](http://bettermedicarealliance.org/sites/default/files/2017-07/Understanding%20Risk%2AdjustmentJune2017.pdf); HUD-assisted population: <http://aspe.hhs.gov/daltcp/reports/2014/HUDpic.pdf>

Given the relatively small property sizes and variations in resident insurance coverage, one health care or insurance provider is unlikely to have a sufficient volume of patients or plan members in any one senior housing community to justify investing in a housing plus service model.

Property Variation

Populations across buildings are also likely to vary in characteristics like age, risk profiles related to health and functioning, and Medicaid/Medicare type. Moreover, the availability and capacity of the service coordinator can vary across buildings. This means existing service coordinator funding leveraged by a financing source will differ across housing communities. It also means that the intensity or type of services may need to vary across buildings to ensure that resident needs are being met appropriately. These variations may cause challenges in scalability.

Population Health

Affordable, independent housing settings have no health or functional eligibility criteria that residents living in the setting must meet. This means residents can vary in their risk levels. Some residents may be considered low risk because they have few health challenges, some may be considered moderate risk because they are managing chronic conditions, while others may be considered high risk because they have multiple chronic conditions and functional limitations.

This variation raises questions about whether insurers or health care providers have an incentive to focus on residents at lower or medium risk who may not currently incur high costs but who may very well become high utilizers in the future. It should be noted, however, that the overall Medicare population receiving HUD assistance has been found to be at elevated risk for high health care utilization, compared to the general Medicare population.¹⁰

Licensing and Credentials

Affordable senior housing communities are not licensed residential settings and operators are careful to avoid actions that could trigger the imposition of state licensing requirements. These state-specific requirements could influence what services communities choose to provide, how those services are provided, who can provide the services, and who can bill for them.

In addition, housing communities are generally not eligible to provide or bill for Medicare- or Medicaid-covered services. Most housing properties would likely not want to—or be able to—provide or bill for these services because they lack the capacity to create the data infrastructure required for Medicare/Medicaid, are worried about potential liability, and have licensing concerns.

In addition, service coordinators typically are not credentialed or licensed in any formal or professional capacity and the education and training of service coordinators can vary, although many are social workers.

Geographic Variation in Medicare or Medicaid Products or Initiatives

Across states and localities, there is variation both in Medicare/Medicaid managed care penetration and in the presence of health care delivery and payment reform initiatives that may incentivize health entities to collaborate with affordable housing communities. Affordable senior housing residents could be enrolled in managed care or participate in these value-based initiatives.

While MA participation is increasing, penetration varies across states, ranging from less than 20% in some states to over 40% in others.¹¹ In addition, there can be multiple MA plans available in a local market and MA plans can serve varying geographic markets.

Many states have transitioned to mandatory Medicaid managed care. As of March 2018, 39 states had contracts with managed care organizations (MCO).¹² However, variability exists in whether dually eligible individuals or

persons receiving LTSS are included in Medicaid managed care and whether their participation is mandatory.

Eleven states are currently participating in the Financial Alignment Initiative managed by the Centers for Medicare & Medicaid Services (CMS). The initiative is testing ways to increase the effectiveness of Medicare and Medicaid programs serving dually enrolled beneficiaries. Nine of these states are working under managed care initiatives that have created Medicare-Medicaid plans to support better coordination and delivery of care for dual eligible beneficiaries. Some states have included the entire state in their plans, while others cover limited regions. Some states are focusing on certain population groups that are delineated by age or service need. Participation has generally been low, with roughly one-third of eligible beneficiaries enrolling.¹³

Several health provider entities are participating in ACO initiatives. There are currently two primary types of Medicare ACOs: Medicare Shared Savings Program and Next Generation. Each type of ACO has different beneficiary assignment processes and risk and reward structures. These differences may influence a provider entity's potential interest in collaborating with affordable housing communities. In addition, the presence of ACOs varies across communities. ACOs are generally clustered in urban and suburban areas and some cities may have multiple ACOs.¹⁴

Because of this variation in FFS and managed care availability and penetration, and the availability of value-based initiatives, some geographies may offer greater incentives or opportunities for housing plus services models than others. As a result, scalability across the country could be fragmented.

Health Care Operational Strategy

Value-based reform efforts might encourage health plans to reach out to community-based service providers to help plans:

- ➔ Expand their care coordination efforts.
- ➔ Gain a more comprehensive understanding of their clients/patients by working with community-based providers that may be closer to those clients/patients.
- ➔ Address social determinants of health.

However, plans often prefer to create their care coordination capacity "in-house" rather than connecting with existing community-based organizations. This preference can pose a challenge to housing plus services models that are trying to coordinate across multiple payers to fund a specific set of service-enriched services.

There could be several reasons behind the preference of plans to create their own care coordination capacity, including their:

- ➔ Desire for control.
- ➔ Belief that a service must be delivered in a certain way.
- ➔ Concern about the skill/capacity of other organizations/providers.
- ➔ Perception that plans are required to deliver services directly.
- ➔ Lack of capacity to organize existing community-based organizations into a network.
- ➔ Belief that once plans ask CMS to approve a "model of care" for members, they cannot deviate from this model.

Many plans view the development and implementation of a model of care for members as a core competency. This model almost always has a care management function at its center.

Terminology Differences and Confusion over Roles and Functions

Health care and housing entities do not always share a common understanding of terms. This can lead to misunderstandings or missed opportunities.

For example, housing and health care entities may have a different understanding of what “care coordination” entails and whether both entities would be doing the same thing. A related concern exists over what it means to “delegate” care coordination responsibilities to a housing property. In fact, the property may be acting as an “extender” of the health plan by carrying out tasks that plan is unable to carry out, or sharing knowledge that the plan does not have.

These sometimes-conflicting understandings are usually related to concerns about duplication of services, the qualifications required to deliver certain benefits, and an unwillingness to relinquish control over and accountability for patient management and outcomes.

Medicare and Medicaid Opportunities and Challenges

Medicare and Medicaid offer opportunities to create mechanisms to support housing plus services models through existing benefits or through adaptations based on other finance and delivery reform initiatives. Several challenges also exist. Below is a discussion of issues within the Medicare and Medicaid benefit and service delivery structures that can inform the most feasible path for developing a financing mechanism for housing plus services models.

Medicare and Medicaid are complex programs. This discussion presents a high-level overview of these issues. Additional concerns or opportunities may exist that are not captured in the following exploration.

Medicare and Medicaid Shared Requirements

Medicare and Medicaid share some statutory and regulatory requirements that pose challenges for creating affordable senior housing-based benefit options.

Freedom of Choice: Medicare and Medicaid guarantee beneficiaries the right to choose their providers. This means that residents of an affordable housing community generally cannot be required to use a specific health care provider or enroll in managed care. This restriction could make it difficult for health entities to identify a large enough volume of residents in any one housing community to justify an investment in the housing-based services model.

States can, however, request waivers to Medicaid's statutory requirements, including the freedom-of-choice provision. For example, waivers can be sought to require that certain individuals enroll in a Medicaid managed care program. Requesting a waiver involves a complex application and approval process. In addition, the waiver must be renewed periodically.¹⁵

Medicare does not have a similar waiver option. Medicare beneficiaries may, but cannot be required to, join an MA plan. Once Medicare and Medicaid beneficiaries are enrolled in a plan, they must be allowed to see any provider within that plan's network.

Uniformity/Comparability: Medicaid and Medicare have related requirements ensuring that beneficiaries receive a common set of benefits. All Medicare beneficiaries must receive the same standard set of benefits. MA plans may offer additional services not provided in this standard benefit package, but these supplemental services generally must be offered uniformly to all plan enrollees. Special Needs Plans (SNP), a type of MA plan, are allowed by statute to restrict enrollment to three specific groups of Medicare beneficiaries, including those who are dually eligible for Medicare and Medicaid, live in institutions, or have certain chronic conditions. The uniformity requirement may pose challenges to creating a Medicare benefit that is limited to beneficiaries living in specific housing settings.

Under Medicaid's comparability requirement, a Medicaid benefit generally must be provided in the same amount, duration, and scope to all beneficiaries. States, however, may request waivers that allow them to provide an

enhanced benefit package to a targeted group. For example, states commonly use waivers to offer home and community-based services to a limited set of enrollees as an alternative to institutional care.

Eligible Providers: Medicare and Medicaid both stipulate the types of providers that can deliver billable services. Often, these stipulations require that providers have certain clinical credentials or some form of certification. In some cases, those delivering services can be supervised by a properly credentialed individual. Although these provider requirements are not an absolute barrier to supporting housing-based services models, they may lead to some challenges or concerns about staff capacity in the housing community. Of particular concern is the service coordinator, since the wellness nurse is already a licensed provider.

Person-based Payments: Medicare and Medicaid benefits are delivered to specific individuals. Benefits cannot go to “places.”

Traditional Medicare

Medicare benefits are provided through two mechanisms: Traditional Medicare, also referred to as Fee-for-Service Medicare, and Medicare Advantage. Beneficiaries can choose which option they want to use.

With Traditional Medicare, beneficiaries can see any provider that accepts Medicare, and no referrals are needed. Medicare pays providers directly for each billable service they provide. Historically, providers of Traditional Medicare services bear no financial risk for the outcomes of those services. More recently, however, many providers are entering into value-based payment models, such as ACOs, which will be discussed later.

Challenges associated with using Medicare to fund housing-based services include limited flexibility and requirements that are generally at odds with the types of services provided in a housing-based services model. For example, Medicare generally:

- ➔ **Only pays for “medically-necessary” services.** These services include “health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, and that meet accepted standards of medicine.” Medicare generally does not cover health education and wellness programs. However, it does cover education benefits tied to specific diseases such as diabetes and kidney disease, counseling for smoking cessation, and an annual wellness visit.¹⁶
- ➔ **Only pays for specific benefits** provided to a specific beneficiary.
- ➔ **Only pays for specific services** provided at a single point in time.
- ➔ **Requires that beneficiaries face cost-sharing requirements.** Beneficiaries must typically pay 20% for most services provided under Medicare Part B, which covers services provided outside of a hospital setting.¹⁷

Under the housing plus services model, services:

- ➔ **Would not always be considered “medically necessary:”** Many types of services provided through the housing-based services model—including assistance accessing benefits and resources, care navigation, and health education and wellness programming—would not meet Medicare’s definition of “medically necessary.”
- ➔ **Are not delivered as a one-time service:** Housing-based assistance is often provided as an episode of care rather than as the one-time service covered by Traditional Medicare. For example, a service coordinator may require multiple contacts to help an individual secure nutrition assistance or other types

of public benefits. Multiple encounters with an individual may be required for a wellness nurse to provide coaching for chronic condition management or monitoring after a hospital stay. In addition, housing-based staff may provide group programming as well as one-on-one assistance.

- ➔ **Are not all provided by allowable providers:** Service coordinators are not considered allowable Medicare providers, and housing properties are generally not connected to organizations with allowable providers that could supervise or oversee the care that service coordinators would provide to their residents.

Despite these challenges, however, there is room for optimism. Medicare has introduced more flexible benefits and opportunities through value-based initiatives that could support housing plus services models.

Flexible Benefits: Medicare has developed a few benefits that better align with the processes needed to manage and coordinate ongoing needs in a flexible manner. They include:

- ➔ **Transitional Care Management:** This benefit, introduced in 2013, supports a beneficiary's transition home after discharge from a hospital or skilled nursing/rehabilitation setting. The benefit, designed to prevent an avoidable readmission, runs for a 30-day period and includes such services as clinical monitoring, education, coordination across physicians, and referrals for needed community services.
- ➔ **Chronic Care Management:** This benefit, created in 2015, acknowledges the time needed to manage and coordinate care for individuals with significant chronic conditions. The benefit allows for the time needed to create and coordinate a comprehensive care plan addressing medical, functional, and psychosocial needs.
- ➔ **Medicare Diabetes Prevention Program (MDPP):** Created in 2017, MDPP is a structured behavior-change intervention that aims to prevent the onset of type 2 diabetes among Medicare beneficiaries with an indication of prediabetes. The program consists of a minimum of 16 intensive group sessions that present a curriculum approved by the Centers for Disease Control and Prevention. The curriculum provides practical training and behavior-change strategies to facilitate long-term dietary change, increased physical activity, and weight control. MDPP is provided by community-based groups such as the YMCA.

These benefits still come with some constraints. For example, they must be provided by certain health professionals, are limited to certain beneficiaries, and beneficiaries incur co-pays. These co-pays may come as a surprise to beneficiaries, especially if they did not receive in-person care coordination services. However, the benefits, along with additional billing codes for coordination introduced in the 2019 Physician Fee Schedule, show that CMS is interested in incentivizing and supporting better care coordination.¹⁸ The benefits provide a potential framework for a more fluid benefit that would allow a range of assistance to be provided over time to support a beneficiary's health management.

Value-Based Payments: The Affordable Care Act (ACA) and the Medicare Access & CHIP Reauthorization Act (MACRA) have helped shift Medicare FFS payments toward value-based payments.¹⁹ These efforts have created opportunities and incentives for thinking differently about care delivery, including how social needs may impact a person's ability to manage care or coordinate across care providers. Initiatives created under these acts may open up opportunities or inform mechanisms that could support the housing-based services benefit.

Accountable Care Organizations

ACOs are groups of doctors, hospitals, and other health care providers that work together voluntarily to provide high-quality, coordinated care to the Medicare beneficiaries they serve. ACOs are designed to incentivize better—not more—care. If an ACO can reduce the health care costs of the patients for which it is responsible, and meet

certain quality benchmarks, it gets to share with Medicare in a portion of the savings achieved.

ACOs have the flexibility to invest in services that could help them deliver better care and supports to help keep patients healthier. These services could include housing-based services models, which may benefit patients who live in senior housing properties and for whom ACOs are accountable.

Despite this potential, however, some ACO requirements, incentives, and practices create challenges for supporting the housing-based services model:

- ➔ **Patient volume:** Beneficiaries are attributed to an ACO based on the providers that deliver a plurality of their primary care during the year. An ACO could be accountable for a concentration of Medicare beneficiaries in a housing community, but this is not always the case, particularly in geographic areas that have multiple ACOs. Additionally, ACOs must serve a minimum number of beneficiaries that could range from 5,000 to 10,000 patients, depending on the type of ACO.

The relatively small size of a typical housing community, and the fact that all residents may not be attributed to a single ACO, may make it difficult to convince ACOs to partner with a housing community. ACOs may not see residents in a single housing property as a substantial enough portion of their attributed population to warrant an investment in housing-based services. These ACOs may not be thinking about the possibility of working with a network of housing communities and organizations that could give them a large enough volume of beneficiaries to justify an investment. Even if ACOs have considered this possibility, they may not know how to assemble such a network.

- ➔ **Patient stratification:** ACOs generally stratify patients into high-risk, rising-risk, and low-risk categories. They generally focus their efforts and investments on high-risk patients who are more likely to use expensive health care services and who offer a greater opportunity to achieve cost savings.²⁰ One stakeholder interviewed during this exploration observed that ACOs are unlikely to think about adding resources to serve a population that is relatively stable. While affordable senior housing residents represent a higher risk population overall, not every housing resident is high risk.

While ACOs also address the rising-risk population, they tend to do so with lower cost and less-intensive interventions. A survey of ACOs found, for example, that only 11% to 21% of ACOs conduct in-home follow-ups with patients following a hospital discharge.²¹ Instead, these follow-ups are generally conducted by telephone.

- ➔ **Staff roles and placement:** The role of the wellness nurse in the housing-based services model is similar to a “community-based care manager” role in which some ACOs already invest. However, ACO care managers generally engage with patients by telephone and not in their home.

ACO case managers also tend to be attached to primary care practices and work with patients in a particular practice and not across the ACO. One ACO representative observed that most ACOs probably do not conduct geographic analyses to detect clusters of higher risk patients. This type of analysis, if conducted, could lead ACOs to find value in realigning the care manager position to serve a housing-based cluster of higher risk patients, according to the ACO representative.

- ➔ **Medical comfort zone:** Some individuals interviewed by the research team perceived ACOs as being slow to get out of their “medical comfort zone” by thinking about ways to best help patients manage their care. These interviewees felt that, generally, ACOs have not thought much about the social determinants of health, nor considered partnering with community organizations that could help patients address the health challenges associated with such issues as low incomes, limited education and literacy, dangerous or unhealthy physical environments, unhealthy lifestyles, and limited access to health services.

A potential advantage, noted by one interviewee, is that ACOs are new to providing care management and may be less committed to a particular care management approach or to the belief that ACOs must deliver care management services directly. This belief would contrast with MA plans, which often cite the importance of their particular care management process as a reason why they must deliver a service using their own staff.

Patient Centered Medical Homes

A Patient Centered Medical Home (PCMH) is a team-based model of care through which a physician practice is responsible for providing for all a patient's health care needs or coordinating care with other providers. PCMHs provide preventive services, treatment of acute and chronic illness, and assistance with end-of-life care.

Currently, PCMHs do not receive reimbursement for many of their core activities, which can include care team meetings, patient self-management education, care coordination, data analysis, and communication with other clinicians. New payment mechanisms are being developed and tested to support these activities. Those mechanisms include new billing codes for services that have not been reimbursed traditionally, enhanced FFS rates, lump-sum payments, shared savings, or combinations of these mechanisms.

A study of PCMH care delivered to older adults found physicians and staff identified multiple gaps in delivering care to this patient population. Implementation challenges included identifying older adults' life needs and linking older adults with community resources, and care management and coordination, particularly around self-management support.²²

Given the similarity between PCMH services and the types of services that would be delivered in a housing-based services model, the creation of payment models for PCMHs may inform possibilities for service benefits in affordable housing settings. Additionally, the study of PCMHs serving older adult patients reveals that these clinical practices would find value in partnering with affordable housing communities to help fill gaps in areas where the practices lack capacity.

Comprehensive Primary Care Plus

Comprehensive Primary Care Plus (CPC+), which is based on the PCMH model, is testing a payment structure for delivering comprehensive, coordinated care in order to lower use of unnecessary services that drive high health care expenditures. Participating practices receive a care management fee, which can be used to augment staffing or to support other resources needed to manage the care of attributed patients. Practices also receive performance-based bonus payments when they meet quality and utilization metrics.

CPC+ is an advanced Alternative Payment Model (APM). APMs are payment approaches that give providers added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.

Like ACOs, PCMH or CPC+ practices could consider collaborating in some way with affordable senior housing communities. However, achieving a large enough volume of attributed beneficiaries in a housing community, or over multiple communities, may be difficult for most primary care practices. Such volume would be required to incentivize an investment in housing-based services.

Medicare Advantage

Medicare beneficiaries can also receive their benefits through Medicare Advantage (MA), which is delivered by managed care plans. MA plans must cover all services offered under Traditional Medicare. They can also offer supplemental benefits, like coverage for vision, hearing, and dental services. Plan members must see providers within the plan's network.

MA plans receive a capitated, monthly rate to provide all a beneficiary's Medicare Part A and Part B services. Because plans receive a fixed amount for each beneficiary, they are incentivized to help plan members stay healthy and minimize use of unnecessary health care services. To help reach this goal, plans may emphasize wellness and prevention services or provide care coordination supports. This focus may spur greater interest or provide increased opportunity for MA plans to support housing plus services programs in some way.

MA plans have several other features and requirements that may influence their interest or ability to support housing plus services models.

Medical Loss Ratio: At least 85% of the premiums that MA plans receive must be spent on medical and quality-improvement activities, as opposed to administrative costs and profits.²³

Medical activities include claims paid for all Part A and Part B benefits and any supplemental benefits. Quality-improvement activities must be primarily designed to:²⁴

- ➔ **Improve health outcomes** through such activities as case management, care coordination, chronic disease management, and medication and care compliance initiatives.
- ➔ **Prevent hospital readmissions** through such activities as comprehensive discharge planning, patient-centered education and counseling, and post-discharge reinforcement by an appropriate health care professional.
- ➔ **Improve patient safety**, reduce medical errors, and lower infection and mortality rates.
- ➔ **Promote health and wellness** through such activities as wellness assessments, coaching, and education programs.
- ➔ **Enhance the use of health care data** to improve quality, transparency, and outcomes, and support meaningful use of health information technology.

Quality-improvement activities must also:

- ➔ Improve health quality.
- ➔ Increase the likelihood of desired health outcomes in ways that can be objectively measured.
- ➔ Be directed toward individual enrollees or for the benefit of specified segments of enrollees, or provide health improvements to the population beyond enrollees.
- ➔ Be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized bodies.

To meet the MLR requirement, MA plans must pay attention to whether the services and benefits they provide are considered medical and/or quality-improvement activities. It stands to reason that many of the services provided in a housing-based services model could fall into both categories. However, some plans may desire confirmation from CMS regarding whether delivery of housing-based services would be considered an allowable medical or quality-improvement activity.

Credentialed Providers: Managed care organizations must ensure the quality of services they purchase, and usually do so by using only credentialed care providers. Service coordinators are not recognized as credentialed providers, and there is currently no defined set of education/skill criteria or practices for this role. This does not necessarily mean service coordinators could not provide services under Medicare managed care. However, some managed care organizations may be unfamiliar with and hesitant about using service coordinators in this role.

Care Coordination: Coverage for “care management” under Medicare is not as robust as it is under Medicaid. This is due to Medicare’s focus on clinical needs and medical necessity. Medicaid, on the other hand, takes a more holistic approach to supporting individuals with multiple chronic conditions and functional limitations and recognizes the value of coordinating care around those needs.

Uniformity of Benefits: A uniformity requirement dictates that an MA plan’s benefits and cost sharing must be the same for all plan enrollees. However, a recent rule change and legislation has opened the possibility for flexibility in providing select benefits to sub-populations of enrollees.

In April 2018, CMS published a final rule reinterpreting the uniformity requirement to allow plans to offer specific, tailored, supplemental benefits to enrollees who meet specific medical criteria. The benefits still must be provided so “similarly situated” individuals are treated uniformly.²⁵ In addition, the Bipartisan Budget Act of 2018 provided the CMS secretary with the authority to waive the uniformity requirement with respect to supplemental benefits provided to a chronically ill enrollee.²⁶

While both changes open an opportunity for MA plans to serve sub-populations, the defining criteria focus on specific medical needs. In housing communities, however, the resident population experiences a range of chronic conditions and medical complexities. This range of needs could make it difficult to serve the entire housing population through an MA plan. It is unclear, however, whether a housing-based services benefit would run afoul of the uniformity requirement, since the types of services provided may be available to all members, but delivered through different mechanisms in the housing community.

In January 2019, CMS announced an expansion of the Value-Based Insurance Design (VBID) model that provides participating plans with additional flexibility to provide customized, additional, supplemental benefits based on socioeconomic characteristics such as low-income status.²⁷ VBID is testing MA innovations that are designed to improve health outcomes and lower Medicare expenditures. Prior to this model update, additional benefit customization was only focused around chronic conditions.

This additional flexibility may inform or open opportunities for plans to target collaborations with affordable senior housing communities that base their eligibility on low-income status.

Supplemental Benefits: MA plans are currently allowed to offer supplemental benefits that are not covered by Traditional Medicare and are “primarily health-related.” An item or service is primarily health-related if its primary purpose is to prevent, cure, or diminish an illness or injury.

The April 2018 final rule expanded the definition of “primarily health-related” to include an item or service used to diagnose a health condition, compensate for physical impairments, ameliorate the functional/psychological impact of injuries or health conditions, or reduce avoidable emergency and health care utilization.²⁸ Notably, CMS clarified that the final rule does not include items or services designed to influence the social determinants of health.

The Bipartisan Budget Act of 2018 also expanded the definition of supplemental benefits. According to the legislation, supplemental benefits are not limited to “primarily health-related” benefits for chronically-ill enrollees with a reasonable expectation of improving or maintaining their health or overall function. This expanded definition goes into effect in 2020.

It is not clear that the housing-based services model would be limited by what is currently allowed as benefits either under Traditional Medicare or existing supplemental benefits options. For example, readmission prevention and some health education and preventive benefits are currently allowed, although these benefits are limited in what they can include or how they can be delivered.

Managed Care Plans Serving Dual Eligible Beneficiaries

Some Medicare beneficiaries are also eligible for Medicaid. This is especially true in affordable senior housing communities.

Approximately two-thirds of HUD-assisted Medicare beneficiaries are dually eligible for Medicare and Medicaid. These dual eligible beneficiaries have the option of joining a type of MA plan called a Special Needs Plan (SNP). In the 11 states participating in the Financial Alignment Initiative discussed previously, dual eligibles may also enroll in a Medicare-Medicaid Plan (MMP). Enrollment in SNPs and MMPs is relatively small.

Because enrollees in dual eligible plans tend to have more complex needs, these plans generally feature a more robust care coordination function than a traditional MA plan. This is partially due to the inclusion of Medicaid, which has more expansive care coordination services than Medicare.

SNPs must define their model of care, including a description of their care coordination process, staff structure, health-risk assessment tool, individualized care plan, interdisciplinary care team, and care transition protocols. Similarly, MMPs must develop a care coordination plan, which generally identifies a care coordinator; assesses an enrollee's medical, physical, and social needs; develops a plan of care; and monitors and helps enrollees obtain needed services and supports. This greater emphasis on care coordination may encourage plans serving dual eligibles to support housing-based services models that help manage the health and social needs of their members.

Many SNPs and MMPs already work in some way with community-based organizations. Some states require MMPs to contract out care coordination services as a way of building on the expertise of existing care coordinators. For example, Ohio requires that MMPs make some use of Area Agencies on Aging (AAA) for these services.

Participation in housing plus services models does not mean that a managed care plans would have to delegate its care management role to the housing-based staff. Rather, housing staff serves as an extender to the plans' care management function.

Regardless of the degree of collaboration, health plan representatives interviewed for this exploration expressed certain concerns about paying for housing-based care coordination services, including:

- ➔ The potential for confusion about the roles that the plan's care coordinator and the housing community's service coordinator would play, and how those roles would differ.
- ➔ Potential difficulties, real or imagined, associated with billing for housing-based service coordination, since service coordinators are not certified Medicaid providers.
- ➔ The capacity of service coordinators, and the functions they could fulfill for the plan.
- ➔ Issues related to ultimate "ownership" of the plan member, and the communication mechanisms needed to ensure smooth information flow.

Medicaid

Like Medicare, Medicaid benefits can be provided on a fee-for-service basis or through managed care. However, a state Medicaid program can require beneficiaries to enroll in managed care through a Medicaid waiver. Many states have transitioned their Medicaid programs to managed care. However, not all states include beneficiaries who are dual eligible in their managed care programs.

Medicaid may be limited in its ability to serve as a stand-alone solution to finance housing plus services models for these reasons:

- ➔ **Eligibility:** Although a sizable portion of affordable senior housing residents are eligible for Medicaid, not all are. The income and asset eligibility levels for affordable housing programs are higher than they are for Medicaid. The proportion of residents eligible for Medicaid can also vary depending on the income-eligibility requirements of the housing community type.
- ➔ **Coverage responsibility:** Medicare, not Medicaid, covers medical care for individuals over age 65. Medicaid pays Medicare cost-sharing obligations, such as premiums and co-payments, for Medicare beneficiaries who are also eligible for Medicaid. Medicaid also provides certain benefits that Medicare does not, most notably LTSS. However, only a portion of affordable housing residents are eligible for Medicaid-funded LTSS.
- ➔ **Variability:** Medicaid is a joint federal-state program. All states must maintain core eligibility standards and benefits. Beyond that, states can customize their Medicaid programs through their state Medicaid plans, and can submit waiver requests to alter core requirements. As a result, Medicaid programs vary across states. This means that states could choose whether to offer a housing plus services benefit and could implement that benefit in different ways.

Despite these restraints, there is potential for Medicaid to support a housing-based benefit, although providers or payers may encounter some limitations and/or limited incentives.

Targeted Case Management: Medicaid offers a case management benefit that supports certain beneficiary populations' access to needed medical, social, educational, and other services. Currently, AAAs are common providers of this case management service.

Several limitations would prevent the case management benefit from covering a housing-based service. In particular, targeted case management is typically time limited, and could not cover the wellness services provided by a wellness nurse. However, the case management benefit may provide a framework for creating a care coordination benefit that is provided to a select population.

Waivers: States can request waivers to Medicaid requirements so they can implement services for select populations and/or test new models of care delivery. Theoretically, these waivers could be used to allow a specialized benefit for housing plus services models. Waiver applications require significant effort and must be renewed periodically. Because the benefits associated with the housing-based services model would accrue largely to Medicare, a state may not perceive that the financial reward for implementing this model is worth the investment.

Health Homes: The ACA created the option for states to establish health homes under their state plans. As of September 2018, there were 35 approved health home models in 22 states.²² Health homes provide a mechanism for helping Medicaid beneficiaries with chronic conditions better manage their primary, acute, behavioral, and LTSS services.³⁰ Services include:

- ➔ Comprehensive care management.
- ➔ Care coordination.
- ➔ Health promotion.
- ➔ Transitional care.
- ➔ Patient and family support.
- ➔ Referral to community and social services.

States have flexibility in designing the payment methodology for health homes. Most states fund health home services through a capitated, per-member per-month payment.³¹ As with Medicare's PCMH or CPC+ programs, a participating health home provider/team might be interested in working with affordable housing communities to help serve the practice's patients and support better chronic care management. Again, the challenge lies in achieving a large enough volume of patients in or across housing communities to justify an investment in these services.

Medicaid Managed Care

Most states have transitioned their Medicaid programs to managed care. However, several states have not included the dual eligible or LTSS populations in their managed care programs.³² It is unknown how many Medicaid-eligible older adults living in affordable senior housing settings are covered under a Medicaid managed care plan.

Interviewees noted some potential challenges in using Medicaid managed care to support an affordable housing-based services model:

Case Management Responsibility: The shift to managed care has caused much disruption in the case management field. There is significant tension associated with plans bringing the case management function "in house," rather than leaving responsibility for case management with the aging network, which has traditionally provided this service. While a housing plus services model is not designed to usurp or take primary responsibility for all case management functions, some plans may be hesitant to extend any portion of the case management function to another provider.

Risk Levels: Members of a Medicaid managed care plan may receive varying levels of care coordination, depending on their risk levels. For example, one plan in a state that includes all dual eligible beneficiaries in managed care employs care coordination ratios of 1:65 for dual eligible members using LTSS, and 1:120 for dual eligible members who are considered "well dual" beneficiaries.

Plans may not feel they receive adequate funding to cover more intensive services for "well dual" beneficiaries because states have traditionally focused resources on beneficiaries who are experiencing significant illness. However, managed care plans may have an interest in addressing the needs of the broader population as a way to prevent illness and keep members from becoming "high risk" users of more expensive services.

MLR Requirements: Medicaid managed care plans face the same MLR requirements as Medicare plans, including a similar requirement to spend a minimum portion of plan expenditures on medical expenses. Plans, therefore, are hesitant to add services that would have to be covered out of their administrative funds. As with Medicare, however, it is possible that services provided through a housing-based services benefit would be allowable under the MLR.

For example, Massachusetts recently issued a bulletin clarifying that Senior Care Options plans could include housing-related services as countable expenses under the Medicaid MLR.³³ These services could include "supporting staff embedded onsite at housing properties to provide non-duplicative services to residents. This could include funding for housing staff located on-site in senior housing (communities) that provide resident service coordination; wellness programming activities; or providing medical support, such as through a nurse or social worker." Thus far, the cost of these housing-based services has not been included in determining the payment rates the plans receive.

Alternative Service Options: Medicaid managed care plans can cover “value-added” services and “in-lieu-of” services.

Value-added services are services that a plan chooses to provide as a way to improve quality of care and/or reduce costs. These services are not covered under the state Medicaid plan. The cost of these services cannot be included in the plan’s capitation rates, but can be included in the calculation of the MLR if the service is part of a quality initiative.³⁴

Plans are more likely to invest in value-added services that decrease medical utilization or placement in an institutional setting. However, if medical encounters and costs are successfully reduced, this can result in lowered capitation rates, which are calculated using historical claims data. The prospect of a lower capitation rate can serve as a disincentive for plans to provide value-added services. Reduced payment rates lower the funds that plans have available to cover provision of the value-added services.³⁵

In-lieu-of services substitute for services or settings covered in a state plan because they represent a medically appropriate and cost-effective alternative for those services. The actual costs of providing the in-lieu-of service are considered when setting capitation rates, and they also count in the calculation of the MLR. In-lieu-of services must be voluntary.³⁶

Tenancy Support Services: In 2015, CMS issued a bulletin on allowable Medicaid coverage of housing-related activities and services for persons with disabilities.³⁷ The services covered in the bulletin focus on obtaining housing and developing the independent living skills needed to maintain housing.

CMS allows coverage for these services out of the capitated rate if the services are part of a state plan or waiver. Some states allow plans to use savings to support the cost of innovative services, if those services help produce savings.³⁸ In a prior study, LeadingAge found that many states tended to think of housing as a shelter strategy to address the needs of homeless individuals or support transitions from institutional settings back into the community, rather than as a platform or partner for supporting the delivery of health and wellness services.³⁹

Community Health Workers: Examining the use of community health workers (CHW) as allowable providers of Medicaid services might provide some insight into the use or establishment of service coordinators as allowable providers.

A Medicaid rule change in 2014 opened payment opportunities for preventative services provided by unlicensed individuals. The rule now stipulates that “services must be *recommended* by physicians or other licensed practitioners of the healing arts within the scope of their practice under state law.” However, non-licensed staff can provide the services.⁴⁰ To reimburse directly for CHW services, states can file a state plan amendment or request a waiver. Each option requires an intensive application and approval process.

Some Medicaid providers may support CHWs as part of delivery teams funded through value-based delivery initiatives like health homes. States can also require managed care organizations to make CHW services available to beneficiaries.⁴¹

Potential Financing Options

In April 2018, an expert group of stakeholders (see Appendix A) met in Washington, DC, to evaluate the potential financing options outlined below. The group reviewed each option, weighing the merits and challenges identified in this paper and their own experiences in the field.

The potential financing solutions are based on opportunities suggested during interviews with various stakeholders prior to the 2018 convening. While the following discussion reviews the advantages and disadvantages of each solution, it does not consider the political or operational implementation barriers that each solution would face, or the current likelihood of its adoption.

1. Create a housing-based wellness/coordination benefit under Medicare Part B.

Pros

- ➔ Provides a benefit to all Medicare-eligible residents regardless of FFS/MA or provider choice, thus addressing the issue of providers/insurers achieving a large enough volume of participants.
- ➔ Further supports efforts to combine medical and supportive services under a single financing stream.

Cons

- ➔ Requires housing communities/organizations to become Medicare providers/suppliers so they can be paid for Medicare-covered services. To deliver these services, housing communities could collaborate or contract with an external or intermediary entity that is a Medicare-billable organization. (Solution 2, below, addresses concerns about eligible provider/billing entities.)
- ➔ Requires that service coordinators, who are not currently credentialed providers, and wellness nurses have a supervising physician entity under which they would provide services.⁴²
- ➔ Features a single-incident or defined-number-of-visits billing mechanism that does not typically fit the nature of engagement in the housing-based services model. However, the transitional care and chronic care management benefits have provided a framework that incorporates multiple engagements over a period of time.
- ➔ Requires that residents pay a 20% copay.
- ➔ May not be a sufficiently developed evidence base to justify the creation of the benefit on a strictly financial cost-benefit basis. (HUD is currently conducting a randomized controlled trial testing the model described in this paper. The study runs through September 2020.)

2. Create an APM for housing-based wellness/coordination, like CPC+, that could be paid through an umbrella entity, such as an independent practice association.⁴³ Similarly, a model could be crafted based on the Medicaid Health Home framework.

Pros

- ➔ Could give health providers an efficient conduit for providing coordination services to Medicare patients that providers may not have the capacity to provide.

Potential Financing Options

- ➔ Adds a social determinants component to the health focus of current APM and care management fees
- ➔ Helps address issues associated with a housing community/organization becoming an allowable Medicare provider, and with service coordinators and wellness nurses providing and being paid for Medicare-covered services.

Cons

- ➔ Requires that primary care physicians serving a significant number of residents in a housing community agree to participate. The APM entity would need a “credible” tie to a physician, since Medicare payments must go to an eligible provider on behalf of a specific individual.
- ➔ Raises concerns about duplicate billing in instances where, for example, a resident was also assigned to an ACO or other sort of APM, unless the nature of the service was different.
- ➔ Raises questions about whether service coordinators, as non-credentialed entities, could provide services under Medicare. Working as part of a team and/or under supervision of a credentialed provider may nullify that requirement.

3. Create a mechanism that aggregates volume of attributed beneficiaries in housing communities for ACOs. Potential paths could include:

3a. Create an intermediary network, like that described in Solution 5 for managed care plans, through which ACOs could purchase housing-based wellness/coordination services.

3b. Assign housing community buildings and their FFS beneficiaries to a specific ACO based on geography.

Pros

- ➔ Aggregates patient volume for ACOs.
- ➔ Provides ACOs with a more efficient contracting and delivery opportunity, as opposed to working separately with multiple housing communities/organizations.
- ➔ Allows for purchase of a service that can efficiently adjust contact intensity based on beneficiaries’ varying risk. This solution gives ACOs a mechanism for touching rising-risk and high-risk beneficiaries.

Cons

- ➔ ACOs are not available in all communities, so this solution would not provide a financing opportunity for housing communities in all geographies.
- ➔ If ACOs in an area did not participate, some residents would not be covered by the funding mechanism. (3a)
- ➔ Not all residents will have primary care physicians who participate in an ACO. (3a)
- ➔ May be challenging to divide up buildings in communities with multiple ACOs. (3b)
- ➔ Would require making an exception to the ACO attribution process. (3b)
- ➔ ACOs may not have adequate capacity to interact and coordinate with social service organizations and to establish data communication flow.

4. Allow housing-based wellness/coordination as a MA supplemental benefit. This could occur if:

- 4a. Plans work one-on-one with individual housing communities or with organizations that own multiple housing communities.
- 4b. Plans work one-on-one with a network of housing providers composed of either a single organization or multiple organizations.

Pros

- ➔ Helps a plan increase patient volume by aggregating plan members.
- ➔ Takes advantage of recent federal action making it possible to reinterpret regulations governing the uniformity rule and allowable supplemental benefits. (Note that these actions are still tied to “chronically ill enrollees” or “meeting specific medical criteria.”)
- ➔ Allows plans to offer a flexible benefit, compared to a typical single-incident FFS benefit.

Cons

- ➔ Does not cover FFS residents.
 - ➔ Some plans might offer the supplemental benefit while others decline, because plans can choose what supplemental benefits to offer.
 - ➔ Since “care coordination” is a core benefit for MA plans, it is not clear whether the housing-based wellness/care coordination benefit could be, or would need to be, offered as a supplemental benefit.
 - ➔ Plans could encounter administrative burdens when contracting with multiple housing communities. However, that burden may be no different than the current burden of contracting with all other providers.
 - ➔ Housing communities/organizations could encounter administrative burdens when contracting with multiple plans that have different requirements.
 - ➔ Some plans may be concerned that there is not enough evidence of return on investment for the benefit.
 - ➔ Some plans may have trouble identifying members living in housing communities. This lack of information would make it difficult for those plans to decide whether to work with housing communities, and which properties would make good partners.
5. Create intermediary entities that serve a network of housing communities through which MA plans, including SNPs and MMPs, purchase housing-based wellness/coordination as a supplemental benefit. This represents a multi-plan, multi-housing community approach. The intermediary entity could also work with provider entities such as ACOs and other value-based primary care entities.

Pros

- ➔ Aggregates a volume of residents/plan members. This could improve the business case for plans and ensure wider coverage of housing community residents.
- ➔ Provides a mechanism for plans to leverage total patient volume and shared staff so they can provide a benefit for members living in a housing community with only a few plan members.
- ➔ Creates an entity that is eligible to bill Medicare, and eliminates capacity and licensing concerns among housing providers.

Potential Financing Options

- ➔ Avoids the need for housing providers to work with multiple plans and meet different service and reporting requirements.
- ➔ Provides a mechanism to also cover FFS beneficiaries.

Cons

- ➔ Does not cover FFS residents, unless intermediary also serves FFS providers.
- ➔ MA plans may hesitate to purchase a common coordination-related service/benefit if they feel it is not on a par with their own coordination model or if they cannot stipulate plan-specific data collection processes and tools.
- ➔ Adds an administrative layer to the housing-based services model, which can increase cost.
- ➔ Would require considerable thought about the model's staffing structure and the relationship between the intermediary and the housing-based staff. This solution raises questions about whether the intermediary employs staff and places them at the community to work with plan members, or if it contracts with the housing community for a share of existing staff time for eligible beneficiaries.
- ➔ Housing communities may still need an additional funding source to support sustainable service coordinator and/or wellness nurse positions if all residents are not covered by a participating entity.

6. Create a housing-based wellness/coordination benefit under Medicaid.

Pros

- ➔ Provides benefits to all Medicaid-eligible residents regardless of whether they are enrolled in FFS or managed care.

Cons

- ➔ Not all residents of affordable housing communities are eligible for Medicaid.
- ➔ The benefit may be created by states under state plans and not at the federal level. In this case, all states may not be willing to create the benefit.
- ➔ States may have fewer incentives to invest in such a change if benefits go largely to Medicare recipients and impact Medicare services/expenditures.

7. Allow managed care plans and housing communities to establish a preferred-provider relationship, which might involve assigning Medicaid plans, including SNPs and MMPs, to specific housing buildings.

Pros

- ➔ Provides opportunity for plans to identify a large volume of residents in one building, thus enhancing the business case for providing a wellness/coordination benefit.

Cons

- ➔ Not all residents are eligible for Medicaid.
- ➔ While states can apply for Medicaid waivers to limit beneficiary choice, it is not clear that this would be allowed under Medicare for plans serving dual eligible beneficiaries.

Vetting Solutions

In discussing the options presented above, participants in the April 2018 convening considered which options seemed most feasible to pursue, given political, regulatory, and practice realities. Here is a summary of their conclusions.

Need for Multiple Solutions

Participants agreed that there is value in affordable senior housing-based services models, and in finding sustainable financing mechanisms to support such strategies. However, most participants believed it may not be possible to identify one solution within the Medicare or Medicaid systems to fund these strategies because:

- ➔ Housing community residents are split between FFS and managed care in both Medicare and Medicaid.
- ➔ Not all residents of affordable senior housing are eligible for Medicaid or Medicaid LTSS.
- ➔ There is great variation across states and localities in Medicare provider and delivery approaches, including the availability of value-based initiatives like ACOs and CPC+ practices, the Medicaid program, and plans for dual eligibles.

Participants generally expressed the belief that separate solutions would be required for the FFS and managed-care realms. They compared approaches that providers and/or insurers could develop within current policy and regulatory parameters to approaches that would require legislative or administrative changes.

Market-Based & Regulatory Approaches

Market-Based Options: Market-based approaches are strategies that providers or insurers could implement within existing regulatory parameters. In order for these approaches to succeed, health systems, risk-bearing primary care networks, or managed care entities would need to be convinced that investments in housing-based services models would help them manage their patients and achieve specific quality or financial goals, including the goal that benefits associated with the solution would justify the costs of the solution. Participants perceived market-based approaches as being more feasible and attainable in the near term, but felt that these approaches may be unlikely to capture all residents in a housing community. Market-based approaches would also take a geographically piecemeal approach, depending on which health entities were interested in supporting the housing-based services model.

Policy and Regulatory Solutions: Approaches requiring administrative, statutory, or other policy changes might include the creation of new benefits or payment models. Experts agreed that these options would be likely to offer broader opportunities for providers and/or insurers to support and scale the housing-based services model. However, stakeholders also expected that these options would be complex to create and would require a longer horizon to implement.

Some experts suggested pursuing multiple paths as a way to allow near-term, market-based approaches to inform and help build the case for larger scale policy and regulatory solutions.

FFS and Managed Care Approaches

Fee for Service: There was interest in exploring development of an alternative payment model for FFS Medicare, based on the PCMH or health home concepts.

Like the housing-based services model, the PCMH and health home models provide a financial mechanism for acknowledging and coordinating services that address an individual's comprehensive needs, not just medical needs.

Creating a FFS payment vehicle would likely be a long-term effort. Stakeholder experts expressed the concern that policy makers may not consider the current evidence for housing-based services models to be robust enough to support creation of a payment model. In addition, the process of recommending new payment models to the U.S. Secretary of Health and Human Services, and vetting those options, is complex and slow moving.

Over the short term, there may be an opportunity for housing providers to collaborate with risk-bearing primary care physician practices or ACOs that are currently implementing alternative payment models, including value-based delivery mechanisms. While these physician practices and ACOs might not fully fund a housing-based services model, they might contract with housing communities to help support their patients in key areas like:

- ➔ Addressing social needs.
- ➔ Coordinating and helping maintain access to care.
- ➔ Monitoring patient conditions.
- ➔ Alerting care providers to potential concerns.
- ➔ Assisting with transitions of care.

This type of support could help physician practices and ACOs improve quality and utilization outcomes for residents who are patients and for whom the entities bear financial risk.

Managed Care: Managed care was generally viewed as a more accessible path than FFS for developing potential financing options. This is due, in part, to the expanded flexibility around the services that managed care plans can offer, how those services are delivered, and the inherent incentives that encourage managed care plans to better manage health care utilization. Most convening participants said they thought it was possible to support the housing-based services model within current Medicare or Medicaid managed care frameworks.

Remaining Issues

Experts identified several internal issues, and external regulatory or policy concerns, that would require attention before a plan might launch a housing-based services benefit or collaborate with housing providers. Stakeholders highlighted the need to better understand:

- ➔ **Staffing roles:** Plans are concerned about potential overlap of or redundancy in services provided by a plan's care coordinator and a housing community's service coordinator.
- ➔ **Impact on plan payments:** Plans need to know that they will get paid for their efforts and that their rates will not be affected if housing-based services are not captured in their MLRs.
- ➔ **Populations served:** Plans may not be open to serving all residents in a housing community. They may be more interested in focusing on residents who are not already receiving more intensive services, including modest-income Medicare beneficiaries who do not qualify for Medicaid. These "near duals" are vulnerable, but generally receive little or no care coordination supports from plans or other community programs. Plans may also want to target residents who are high risk and costlier. The interests of plans may vary depending on whether they are a traditional MA plan, or a SNP or MMP plan that serves dual eligible individuals.
- ➔ **Communication issues:** Plans would need to determine what information and data would be shared between housing-based staff and health entities, and the mechanisms through which that information would be shared.

- ➔ **Return on investment:** Several participants in the convening expressed the opinion that more work is needed to clearly define the value proposition of the housing-based services model for health entities, including net effects on expenditures and quality outcomes.

Experts agreed on the need for a mechanism to address the volume challenge created by the fact that residents of a housing community are affiliated with multiple providers, payers, and insurance plans.

One potential option involves creating some type of intermediary entity to pool resources across providers/insurers. This intermediary would represent an efficient vehicle for pricing, providing, and billing for housing-based services. Additionally, all participating health entities would pool their resources and leverage each other's financial contributions. This approach could lead to a collective and more robust service package for each entity. A corresponding challenge, however, would involve convincing all providers/payers to participate so all residents would be covered fully.

Conclusion

Stakeholders participating in this exploration expressed great interest in and enthusiasm for affordable senior housing-based service coordination and wellness programs designed to help elderly residents with low incomes successfully age in community and avoid the use of unnecessary and higher cost health and LTSS services.

Participants felt that the most feasible approach in the near term would focus on the potential for collaboration between Medicare managed care plans, including dual eligible plans, and housing providers. That collaboration would take place either through direct partnerships or through an intermediary mechanism. While this approach would not provide payment coverage for all residents in a housing community, it is a starting point that could be leveraged with other funding sources until a more comprehensive funding solution could be created.

Participants agreed on the need for more evidence to support a value proposition for the housing-based services model. Suggested next steps for building this support included:

- ➔ Developing and testing models through "real world" partnerships between willing health care and housing entities.
- ➔ Pursuing demonstration authority through the Center for Medicare & Medicaid Innovation at CMS.

Finally, stakeholders emphasized the need to create greater awareness, among policy makers and executives of health systems and health plans, about the potential role that affordable senior housing communities can play as an efficient and effective platform for service coordination, early intervention, and prevention.

Appendix A

Expert Interviewees and Participants in April 2018 Convening

**All listed experts were interviewed. Those with an asterisk before their name also attended the convening.*

Alan Abrams
Beth Israel Deaconess Medical Center ACO
Boston, MA

Michelle Bentzien-Purrington
Molina Healthcare, Inc.
Long Beach, CA

Luarnie Bermudo
San Mateo Health Plan
San Francisco, CA

*Beth Berselli
Gordon and Betty Moore Foundation
San Francisco, CA

*Deborah Brodine
UPMC Community Provider Services
Pittsburgh, PA

Brian Burwell
IBM Watson Health
Cambridge, MA

*Bruce Chernof
The SCAN Foundation
Los Angeles, CA

*Susan Ciccariello
Massachusetts Executive Office of Elder Affairs
Boston, MA

*Emily Cooper
Massachusetts Executive Office of Elder Affairs
Boston, MA

Steve Eiken
IBM Watson Health
Cambridge, MA

*Tim Engelhardt
Medicare-Medicaid Coordination Office
Centers for Medicare & Medicaid Services
Washington, DC

Amanda Hurley
Better Medicare Alliance
Washington, DC

Koren Iskra
UnitedHealthCare Community Plans of
Massachusetts and Rhode Island
Boston, MA

*Gretchen Jacobson
Kaiser Family Foundation
Washington, DC

*Matthew Jennings
UPMC Community HealthChoices
Pittsburgh, PA

Sue Kvendru
Minnesota Department of Human Services
St. Paul, MN

*Dan Lindh
Presbyterian Homes & Services
Roseville, MN

Robin Lipson
Massachusetts Executive Office of Elder Affairs
Boston, MA

*Victoria Loner
OneCare Vermont/University of Vermont
Health Network
Hinesburg, VT

Susan McAllister
AmeriHealth Caritas Pennsylvania
Community HealthChoices
Harrisburg, PA

Andy McMahon
UnitedHealthcare Community & State
Washington, DC

*James Michel
Better Medicare Alliance
Washington, DC

*Michael Monson
Centene
St. Louis, MO

Mary Neagle
Massachusetts General Hospital
Boston, MA

*Len Nichols
George Mason University
Fairfax, VA

Joan Quinlan
Massachusetts General Hospital
Boston, MA

Jennifer Rogers
AmeriHealth Caritas Pennsylvania
Community HealthChoices
Harrisburg, PA

Fatema Salam
Center for Medicare & Medicaid Innovation
Centers for Medicare & Medicaid Services
Baltimore, MD

*Paul Saucier
IBM Watson Health
Brunswick, ME

Ronald Schumacher
Optum
Eden Prairie, MN

Allyson Schwartz
Better Medicare Alliance
Washington, DC

*Melora Simon
San Mateo Health Plan
San Francisco, CA

*Terry Spitznagel
National Church Residences
Columbus, OH

Beth Tanzman
Vermont Blueprint for Health
Waterbury, VT

Katarina Tague
Molina Healthcare of Ohio, Inc.
Columbus, OH

*Susan Tucker
Molina Healthcare
Tampa, FL

Michael Van Scoy
UPMC Pinnacle
Harrisburg, PA

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- ¹ This paper uses the term “housing plus services” models. These models are also referred to as “service-enriched housing” and “housing-based services” models. While similar to “supportive housing” models in concept, the term is not interchangeable, as supportive housing generally refers to models that support homeless/formally homeless individuals.
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- ¹⁶ Centers for Medicare & Medicaid Services. (2018). Your Medicare Benefits. Baltimore, MD: Author. Retrieved from <https://www.medicare.gov/Pubs/pdf/10116-Your-Medicare-Benefits.pdf>.
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