PHC 6146 – Policy Memo

To: Senate Committee on Health, Education, Labor and Pensions
From: Grant Donovan
Date: December 2nd, 2023
Re: Using The FSP Model to Address Housing Instability's Negative Impacts on Public Health

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Too little housing stability exists among low-income residents in U.S. cities. 31% of U.S. households are categorized as "rent-burdened" and considered at risk of housing instability. This has a large, negative impact on public health, as stable housing is necessary for avoiding harmful experiences on the street or in shelters, maintaining regular access to medical treatment, safely storing personal medications, and more. As a result, those struggling with housing instability make up a disproportionate share of Medicaid spending. Currently, healthcare providers have few ways to help Medicaid patients solve their housing challenges. They are instead forced to treat such patients through ineffective, costly, episodic care. Given available research, evidence suggests that costs can be controlled, and better health outcomes produced, by reorganizing Medicaid service delivery around Full Service Partnerships (FSPs). The FSP model builds off the successes of the Accountable Care Organization (ACO) and Housing First models by focusing broad clinical teams on addressing patients' underlying determinants of health. The FSP model would decrease in-patient hospitalization and emergency room use, rein in Medicaid spending, and significantly improve public health.

Background

The Negative Public Health & Healthcare Impacts of Housing Instability

Those struggling with housing instability suffer from higher rates of injury, illness, mental health issues, and death (Maness & Khan, 2014). These are households that must turn to couch surfing, moving frequently, or regularly falling behind on rent to get by. This lifestyle often requires sleeping in shelters or even on the street – environments full of harmful experiences and adverse conditions (Taylor, 2018). The uncertainty of such a lifestyle makes it difficult to maintain consistent employment, regular access to medical services, and even a healthy social life. Finally, these households often have difficulty storing personal medications (Taylor, 2018). Unfortunately, these are not uncommon problems. According to the Census Bureau, over 31% of U.S. households are considered "rent-burdened" and at risk of struggling with housing instability ("How Much", 2023).

Because of the scores of health challenges these households face, those suffering from housing instability demand a disproportionate share of healthcare services (Koh et al., 2020). This poses financial problems for both healthcare systems and state Medicaid programs. For the former, unstable households are among the least likely to pay large hospital bills and the most likely to require long hospital stays (Hawryluk, 2019). But because hospitals have a legal requirement to treat patients that need emergency care, they are often unable to turn such people away. The result is that healthcare systems typically lose thousands of dollars every year treating those suffering from housing instability (Hawryluk, 2019). As for the latter, many such households are insured through state Medicaid programs. As they demand more and more care, then, these households drive up Medicaid spending (Lim et al., 2018). Already, Medicaid is considered too expensive to be sustainable. Most states have been forced to reduce benefit eligibility or apply for federal waivers in attempts to keep Medicaid spending within their budgets (Meacham & Longest, 2021). By disproportionately increasing service demand, Medicaid patients suffering from housing instability magnify spending and thus these budget concerns.

The Housing First Model

Most attempts to address the health impacts of unstable housing have focused exclusively on housing policy. One such attempted remedy was the Housing First model, which focused on providing people with stable housing before any other type of treatment. Cities across the world – from Helsinki, Finland to Salt Lake City, Utah – have managed to drastically reduce their homeless populations through Housing First programs (Henley, 2019; McEvers, 2015). Studies show that these Housing First programs are also correlated with lower emergency room and in-patient hospitalization use (Tsai, 2020). However, most Housing First programs' health impacts are very small. Scholars have come to realize that the problem facing most homeless adults is not just the lack of a home. Instead, many also need comprehensive healthcare and social services to live meaningful, productive lives (Tsai, 2020). These are services that are not provided or required by most Housing First programs, which severely limits their effectiveness.

The Accountable Care Organization Healthcare Delivery Model

There have also been attempts to address the determinants of health through health policy, but these too face shortcomings. The main healthcare delivery innovation of the 21st century has been the Accountable Care Organization (Meacham & Longest, 2021). ACOs were created in an effort to focus providers on treating Medicaid patients comprehensively and efficiently. By paying a clinical team a lump sum for a given condition, physicians were to work together to treat a patient's underlying conditions rather than prescribing unhelpful and expensive episodic care (Meacham & Longest, 2021). However, clinical teams are not given free rein to treat patients any way they see fit. Medicaid payments come with many strings attached; primarily that they be spent on evidence-based clinical treatments (Meacham & Longest, 2021). This is a problem when a patient's underlying condition is not one that can be solved medically. For many patients, adverse behavioral or environmental determinants – such as unaffordable housing – underlie their health issues. By excluding clinical teams from addressing determinants, they must instead continue to treat these patients in the unhelpful and expensive episodic fashion. Predictably, studies show ACOs only result in minor cost savings and have had little impact on patient outcomes (Nyweide et al., 2015).

Analysis

The Full-Service Partnership Healthcare Delivery Model

A novel method for delivering healthcare services to those facing housing instability is the Full-Service Partnership model, which builds upon the ACO and Housing First models. Even though these previous solutions fell short of their goals, lessons can still be learned from them. For example, Housing First programs demonstrated that addressing a patient's housing needs can have significant health benefits, especially when accompanied by comprehensive medical treatment (Tsai, 2020). Similarly, ACOs have proven most effective when they embrace preventative care, follow patients through their entire healthcare journey, and make care convenient for patients (Katsikas, 2021). FSPs apply all of these lessons together. Like ACOs, FSPs bring together a team of specialists to work together to treat Medicaid patients' needs. However, unlike ACOs, FSPs feature a broad team of physicians, social workers, caregivers, and educators. This team focuses on addressing the determinants of health before beginning medical treatment. Often, this means providing a patient with housing vouchers (Sandel & Desmond, 2017). Only then does the team put together a plan of medical treatment. Finally, they follow up with continual out-patient care and community service delivery.

While this model has not been widely applied, it has nevertheless found remarkable success. The primary strength of FSPs is that they have demonstrated a considerable ability to decrease in-patient hospitalization and emergency room use. For example, an analysis of San Diego County's Mental Health FSPs concluded that by limiting the need for such services, they were able to offset 82% of program costs

(Gilmer et al., 2010). Randomized controlled trials validate this casual connection, as FSP-like interventions reduced both hospital stays and emergency room visits among homeless adults by 24% and 29%, respectively (Sadowski et al., 2009). The second strength of FSP models is how they encourage coordination between healthcare and community-service providers. Typically, a disconnect exists between these two groups as they have very different agendas. Healthcare providers are driven to improve intermediate health outcomes and reduce short-term costs. Community service providers, meanwhile, are driven to impact community-level outcomes and focus on long-term costs (Byhoff & Taylor, 2019). The result of this disconnect is the adoption of incompatible strategies and a lack of information sharing. Under these conditions, collaborating to improve patient outcomes is almost impossible. FSPs address this problem by placing these providers on the same clinical team and thus aligning their incentives. Providers are therefore incentivized to collaborate on addressing patients' needs when, where, and how they are most capable.

But despite these benefits, the FSP delivery model also comes with significant weaknesses. The first is the limited range of patients that they typically serve. Providing housing is expensive, and delivering comprehensive care requires much of providers' attentions. As a result, FSP programs have been accused of focusing resources on a narrow group of patients (Gilmer et al., 2010). Many patients that need medical treatment do not struggle with unstable housing, just as many people struggle with unstable housing but not medical issues. FSPs may end up ignoring these groups in favor of those struggling with both. Another weakness is that the FSP model is unlikely to receive much immediate political support. Providing housing assistance would undoubtedly result in short-term increases in Medicaid spending (Gilmer et al., 2014). This would be an unacceptable result for most legislators, as they are largely concerned with controlling Medicaid costs (Meacham & Longest, 2021). Additionally, the FSP model has not been applied to many healthcare systems outside of California or the mental health sector. Politicians may therefore be skeptical of its proposed benefits. The FSP model would first need to be evaluated through CMS innovation center trials and then further evaluated in practice by the most interested states. Only then could this model find the political support necessary to pass through the convoluted national policy formulation process (Meacham & Longest, 2021).

Allowing More Flexibility in ACO Medicaid Payment Spending

An alternative policy solution would be to adjust the current ACO healthcare delivery model to function more like an FSP model. This could be accomplished by increasing the flexibility ACO clinical teams have in using Medicaid payments – specifically allowing them to put resources towards addressing patients' underlying housing issues (Blumenthal & Abrams, 2016). The main strength of this policy is its politically feasible. Expensive housing vouchers would only be considered in cases where they are most essential to a patient's health and therefore a profitable investment for healthcare providers. This would mean relatively smaller increases in Medicaid spending: a much more palatable solution for most elected officials. Additionally, some states have already begun experimenting with this policy. Utah, Oregon, and New York all already allow ACO Medicaid payments to go towards housing vouchers (Spencer et al., 2015). A second strength of this policy is the speed and ease with which it can be implemented. ACOs are already present in many states' Medicaid programs ("Medicaid," 2018). Rather than being forced to reorganize operations and learn an entirely new way of doing things, this policy would simply provide preexisting clinical teams with more treatment options; this is a change that could be accomplished practically overnight.

This policy also comes with significant weaknesses, though. The most prominent of these is that ACOs, even when given the opportunity to address housing needs, rarely do so. Connecting patients with suitable housing requires paying high upfront costs and coordinating with community service providers – two tasks of which healthcare providers are often wary (Byhoff & Taylor, 2019). Also, ACOs are just not used to thinking in terms of the determinants of health. In Utah, Oregon, and New York, ACOs are only slowly

coming to update their billing codes to include services beyond clinical treatments (Spencer et al., 2015). It is not a certainty that allowing ACOs to put Medicaid payments towards patients' housing needs will actually result in those needs being addressed. A second significant weakness is that the ACO model is currently being utilized in only twelve states' Medicaid programs ("Medicaid," 2018). These states contain under one-fourth of the U.S. population covered by Medicaid, which severely limits the range of impact that this policy can have. It would likely need to be accompanied by federal incentives to expand the ACO model into more states in order to have significant impacts on national-level public health outcomes or Medicaid spending figures.

Recommendation

Given these considerations, I strongly recommend that the federal government and the states reorganize their Medicaid payment systems around the Full-Service Partnership healthcare delivery model. It has become clear that addressing Medicaid patients' underlying housing needs will be necessary to improve public health and rein in Medicaid spending. Yet, there is little evidence to suggest that this can be accomplished with current Medicaid payment models. Physicians are trained and conditioned to address patients' needs with medical treatment. Without structural incentives in place to focus them on health's determinants, they will only continue to address patients' needs through inefficient, episodic care. Through the FSP model, Medicaid payments are instead directed to where they would have the most impact. Solving Medicaid patients' housing needs first would allow them to live healthy lifestyles and prevent the need for expensive, episodic medical treatments in the first place. Even the limited FSP models that currently exist demonstrate this as they have significantly reduced in-patient and emergency room costs. Additionally, coordination with community service providers is clearly necessary for comprehensively treating Medicaid patients' needs. Unfortunately, healthcare providers are not incentivized to engage in such coordination under current Medicaid payment models. By placing healthcare and community service providers on clinical teams with one another, their incentives can be aligned and coordination ensured. Altogether, the FSP model would finally encourage providers to deliver the efficient and holistic care that the ACO model was originally promoted to bring about.

And while many argue that reorganizing Medicaid service delivery around FSPs is not feasible, I would argue that maintaining the current system is the infeasible option. Medicaid costs are rising too rapidly for most states to control them. Meanwhile, every year more and more households struggle with housing instability and the serious health complications that come with it. Under these conditions, Medicaid systems will soon become prohibitively expensive while public health deteriorates rapidly. This is an unacceptable situation for most politicians, healthcare providers, and the public at large. Aggressive measures will need to be taken to correct these trends, and the FSP model – built upon the successes of the current ACO delivery system and backed by promising data – is likely to be the most politically feasible option among them. Yes, this model would need to be implemented and evaluated in stages, but the successes of FSPs currently in use suggest it could do so quickly and effectively.

As for the narrow focus of the FSP model, most would agree that we should be directing tax dollars to their most high-impact and cost-effective use. In Medicaid programs, this means addressing the needs of those demanding a disproportionate share of services – those struggling with housing instability. I would argue that these are the patients which should be receiving more focus anyway. Furthermore, if the FSP model significantly reins in Medicaid spending, then that leaves more state resources available with which to then help others in need.

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