



An Exploratory Study of the Affordable Care Act and Housing in Rhode Island
A qualitative analysis of local intersections of healthcare policy and housing

By: Kristina Brown
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WHO IS HOUSINGWORKS RI AT RWU?

HousingWorks RI at Roger Williams University is an authoritative source of information about housing in Rhode Island. We conduct research and analyze data to inform public policy. We develop communication strategies and promote dialogue about the relationship between housing and the state's economic future.

HousingWorks RI at Roger Williams University envisions a Rhode Island in which communities embrace a variety of housing choices so that residents, regardless of income, can live in healthy, quality homes in vibrant and thriving neighborhoods.

ORIGINS & FUNDERS

With funding from the Rhode Island Foundation, Rhode Island Housing, and United Way of Rhode Island, HousingWorks RI began as a campaign to educate the public and business community about a rapidly emerging economic development problem: the lack of affordable housing options for the state's workforce. HousingWorks RI has since evolved to serve as

the foremost clearinghouse for information on housing affordability in Rhode Island and to connect this information with other issue areas including economic development, education, and health.

Roger Williams University has long valued a campus-wide commitment to the greater community and integrated HousingWorks RI as a research center in 2014. As part of Roger Williams University, HousingWorks RI at RWU acts as a bridge for the University and provides a "think and do" laboratory that faculty, students, and staff can leverage to better all of Rhode Island.

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EXECUTIVE SUMMARY

With the implementation of the Affordable Care Act (ACA) in 2014, the healthcare industry was presented with the challenge of increasing insurance coverage and reducing costs of care. In response to the roll out of the ACA, some states developed strategies to reduce healthcare costs through increased housing supports to populations with complex conditions. New York, for example, used early Medicaid savings earned through ACA incentive mechanisms to develop permanent supportive housing and affordable housing. Research shows that permanent supportive housing can reduce utilization of expensive inpatient healthcare services, largely by reductions in emergency department care and nursing home care, for vulnerable individuals. Overall, the work to restructure Medicaid and healthcare under the ACA has broadened the scope of healthcare through creating innovative approaches to care that include social determinants of health, such as housing quality and stability.

Within the first two years of ACA implementation, Rhode Island has seen high enrollment rates, specifically amongst individuals newly eligible for Medicaid through the expansion. Under the new eligibility criteria, the chronically homeless population gained access to healthcare. At the administration level, Governor Raimondo established the Reinventing Medicaid task force to restructure the State Medicaid plan, which produced the Reinventing Medicaid Act of 2015. The goal of the task force is to keep the systems transformation under the ACA on track and reduce overall spending. To understand how reforms under the Affordable Care Act intersect with housing issues in Rhode Island, HousingWorks RI at Roger Williams University conducted a qualitative study investigating the impact of healthcare policy changes on the housing sector. The objective of the study was to understand how the ACA is changing healthcare in Rhode Island in order to identify local initiatives addressing the intersections of healthcare and housing.

Key Findings

- **Local Impact of the Affordable Care Act**

Beyond enrollment rates, the ACA has spurred the formation of Accountable Care Organizations (ACOs) in Rhode Island. Under the Medicaid Coordinated Care Pilot program, Accountable Care Organizations are called Accountable Entities (AEs). ACOs and AEs are conglomerates of healthcare agencies and insurance companies coordinating care for a specific population or membership, most often consisting of hospitals, primary care, and behavioral health. Another layer of healthcare coordination is the development of consistent quality metrics and electronic records. The Executive Office of Health and Human Services (EOHHS) is developing a comprehensive enrollment database for health insurance and social services under the Unified Health Infrastructure Project (UHIP) called RI Bridges. Similarly, the State Innovation Model (SIM) grant, a 20 million dollar grant, is being used to develop an all payer claims database that will provide better data tracking of healthcare utilization across the state.

- **Medicaid Initiatives and Housing**

The Executive Office of Health and Human Services (EOHHS), which administers Rhode Island's Medicaid plan, is working on several initiatives to restructure Medicaid and reduce

inefficiencies. A few Medicaid initiatives have found that a lack of affordable housing and instable or unsafe housing, is a challenge to successfully meeting the goals of the ACA. One example of this is the Money Follows the Person (MFP) Demonstration that is working on rebalancing the number of patients in nursing homes and hospitals safely to community based care. In line with bolstering Home and Community Based Services (HCBS), Centers for Medicare and Medicaid Services (CMS) approved the Home Stabilization Pilot in 2015, which will allow Medicaid reimbursement for housing retention services for low-income elderly and disabled residents. The Section 811 Project Rental Assistance Program is another example of local collaboration across healthcare and housing. The Section 811 initiative is a partnership between Rhode Island Housing and Medicaid's Money Follows the Person Demonstration to integrate supportive housing and healthcare services for persons with disabilities.

- **Individual Organizations Working Across Health and Housing**

Several organizations are actively working or seeking partnership between healthcare and housing. Neighborhood Health Plan of Rhode Island (NHPRI), the largest Medicaid insurer in the state, has built out case management and housing specialist staff in order to meet the needs of expansion members. In gathering data on the expansion membership, NHPRI home visiting staff reported several findings of unsafe housing conditions and hoarding issues. Hoarding and substandard housing can greatly impact health conditions and exasperate chronic diseases like asthma. Other organizations that are working to collaborate meaningfully across health and housing include the Housing Resources Commission, The Providence Center, and Rhode Island Housing.

- **Public Health Initiatives and Housing**

The most frequently referenced collaborations across healthcare and housing were Public Health initiatives, or social service organizations, whose work does not directly relate to the Affordable Care Act beyond insurance enrollment or healthcare reform. However, initiatives like the Health Equity Zones and efforts of the local chapter of Green and Healthy Homes, have been designed to align with the goals of the ACA. There is the hope that the focus on population health under the ACA could potentially broaden reimbursable services to include social services related to population health. There is no evidence at this time that insurance will cover broader preventive services, however, under patient-centered health reform, organizations are looking outward to understand what other services patients can access that will support medical interventions. In line with coordination efforts of traditional healthcare organizations, CMS announced a new funding opportunity designed to bridge clinical and social services called Accountable Health Communities (AHC). The AHC funds require partnership between a community service provider, Medicaid, and a clinical delivery site. This initiative is meant to aid states in strategically identifying and addressing the health-related social needs of communities where Medicaid and Medicare beneficiaries live. The first core need listed in the funding guidelines is housing instability and housing quality.

- **Barriers to Cross-sector Collaboration**

In this study, three sectors were prominent in connection to healthcare and housing: Healthcare, Public Health, and Housing and Community Development. Throughout each stage of research conducted for this study, several barriers to cross-sector collaboration were identified. Overall, there was a lack of knowledge or understanding of the work of other sectors. Amongst key informants, there was a distinct split between those that were excited to collaborate with non-traditional partners and those that felt collaboration outside of healthcare would spread resources too thin. Resistance to collaboration was also apparent within healthcare alone, mainly from hospitals and nursing home representatives that feel they are negatively affected by overall coordination efforts. In both interviews and policy meetings, the lack of flexible funding models was a consistent theme. Lack of flexible funding enforces silos and creates many challenges to formal collaboration. Due to these barriers, many practitioners rely on informal professional relationships to meet the needs of their clients or patients. Another significant barrier to cross-sector work is the pervasive use of similar terminology that has different meanings. Universal definitions of phrases like “housing interventions” do not exist; therefore working collaboratively requires an added layer of education.

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1. INTRODUCTION

Over the past decade, research has shown that access to stable housing can improve population health outcomes. Across the country, unique programs coordinating services between housing and healthcare show housing can also reduce healthcare costs. However, barriers between the Healthcare and Housing sectors have made it difficult to coordinate care across the two. With the recent implementation of the Affordable Care Act, healthcare professionals have been given the incentive to look at ways to streamline payment and delivery methods across different healthcare providers and practitioners. Although housing is known to stabilize patients and improve health outcomes, much of the current reform efforts are working to better coordinate care within the traditional healthcare system.

A few states, however, have determined that a better way to coordinate care for the highest utilizers of the healthcare system and reduce cost of their healthcare services, is to address patients' housing issues. Recognizing that health is determined by a variety of interrelated factors known as "social determinants of health," states are looking to connect healthcare, public health, and social services to achieve improved population health and reduce cost of care.ⁱ One compelling example of this is "Housing First," a practice that is already well established across the country within the supportive housing and behavioral health sectors. However, broadly considering healthy housing as part of the continuum of healthcare is a relatively new concept. Research shows that housing insecurity, including substandard living conditions, is a known threat to health, specifically for children. By understanding predictors of housing insecurity, policies can be made to protect our most vulnerable populations.ⁱⁱ

The purpose of this study is to understand the impacts of the Affordable Care Act in Rhode Island and identify ways that healthcare reform intersects with housing both locally and nationally. The study consists of several parts, starting with an extensive literature review of research from healthcare and housing organizations, and from government documents and local initiatives, including Reinventing

Medicaid, the State Innovation Model (SIM) Grant and the 1115 Waiver amendments. Qualitative data was collected through key informant interviews with twenty-six local policy experts and practitioners. Subsequent research was conducted through systems analysis of both the healthcare system and housing supports system. Finally, a professional network analysis was conducted through a qualitative survey of the same sample of twenty-six informants.

Key findings show that under the Affordable Care Act, there is a national trend toward supportive services being integrated into healthcare services for specific populations. Locally, there are persistent barriers to understanding the Housing and Healthcare sectors, and the larger role of Public Health within healthcare reform. Due to these barriers, collaborations across health and housing have been slow to start and in some instances, have been met with resistance. Some areas of reform—notably Medicaid expansion under the ACA—show potential for cross-sector collaboration.

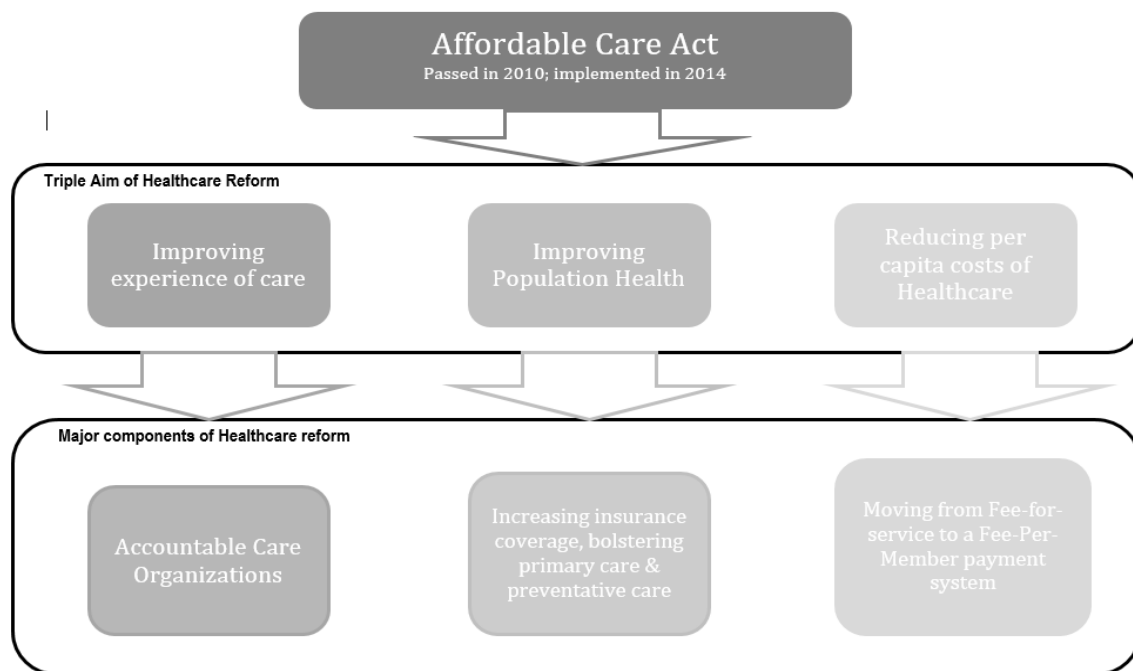
2. LITERATURE REVIEW

2.1 Overview of the Impact of the Affordable Care Act

The Affordable Care Act (ACA) refers to two pieces of legislation, the Patient Protection and Affordable Care Act and the Health Care Reconciliation Act, both passed in 2010. The intent of the ACA was to create policies that address national issues of poor population health and soaring healthcare costs through comprehensive health insurance reforms. Broadly, the largest impact of the ACA to date is mandating enrollment in health insurance through state and national healthcare exchanges. Another controversial part of the original legislation was expansion of Medicaid to cover low-income childless adults, a population that was previously identified as not having access to healthcare. Due to public resistance of Medicaid expansion for childless adults, it was not mandated nationally, and individual states were able to choose whether or not they would participate. In order to support those states choosing to expand Medicaid, the Federal government offered substantial funding to assist them in

building capacity to care for this new population. Beginning in 2014, newly eligible adults were fully funded by the Federal government for a three-year period, with subsequent reduction of Federal funds.ⁱⁱⁱ

Beyond expansion of health insurance coverage and enrollment, the overarching goal of the ACA is healthcare systems transformation with the aims of improving population health, enhancing patients' experience of care, and reducing per capita costs. In order to achieve these aims, the ACA has established various incentives for healthcare providers and insurance plans to move from fee-for-service to a fee-per-member-per-month payment system. Fee-per-member systems encourage coordination of care and hold providers and insurance companies accountable to their patients and members. Through the development of Managed Care Organizations (MCOs) and the creation of Accountable Care Organizations (ACOs), the ACA is encouraging consolidation and collaboration across the many isolated systems within healthcare.



ACOs are entities made up of healthcare providers, organizations, and institutions that collaboratively coordinate the healthcare of patients or insurance plan members. Across the country, ACOs are beginning to form in a variety of ways. Many ACOs are strategic partnerships between

hospitals, behavioral health organizations and primary care providers. The goal of an ACO is to improve care management and quality of care through an integrated delivery system, while reducing the overall cost of care to the population.^{iv} Under the ACA, ACO structures aid in the transformation from a volume-based system to a value-based system, meaning that healthcare institutions that formerly made more money by serving more patients will now be getting more money for keeping people out of institutions through managing patient care in a more effective way. Essentially, the goal of this transformation is to improve overall health within the larger community and better serve the needs of those that are costing the system the most. Medicaid requires that ACOs meet quality of care standards and will issue ACOs a share of any savings when they deliver healthcare at lower costs than budgeted per-member.^v The Medicaid savings that result from reducing costs through more effective care is the incentive mechanism that is driving institutional transformation in the healthcare system.

Accountable Care Organizations, at this stage of development, are all unique. In the broadest sense, ACOs are conglomerates of different types of healthcare, and in some instances social service providers, that agree to share the financial risk as well as savings of reducing the cost of care of a specific group of members. It is thought that through ACOs, the system of care delivery will be more efficient and more cost effective taking the brunt of the burden off of state and federal governments. As coordination across healthcare organizations that serve different populations become established, and data on those populations become more readily available, there may be opportunities to systematically address social determinants of health. ACOs force hospitals and other healthcare agencies to create formal partnerships to manage the care of a number of patients, in addition to being accountable for managing the utilization of a spectrum of services. In this climate, it would be in the best interests of ACOs to start to think outside of the traditional continuum of care systems to reduce expenses related to meeting the needs of their most complex patients. In other words, ACOs in attempting to reduce the cost of care, may identify needs to address housing or other social determinants for their members in

order to stabilize and effectively treat members' chronic illnesses. However, at this nascent stage, the main focus of transformation is to create new systems within healthcare and lay the infrastructure for doing business as Accountable Care Organizations.

Another significant change in healthcare, under the ACA, is the inclusion of Behavioral Health services as an essential benefit under all insurance plans. Behavioral Health services include psychotherapy and counseling, substance abuse treatment, and mental or behavioral health inpatient services. Insurance plans are not allowed to deny coverage to individuals with pre-existing mental or behavioral health conditions, and spending limits are not allowed to be placed on these services.^{vi} Due to these changes, Behavioral Health providers are playing a more significant role in healthcare reform and the formation of ACOs.

2.2 National Initiatives Addressing Health and Housing

The big push in healthcare reform under the Affordable Care Act is to transform the system from fee-for-service delivery to coordinated care, commonly referred to as moving from volume-based payment to value-based, and the majority of this transformation has been within the Medicaid expansion population. According to the Rhode Island Office of the Health Insurance Commissioner, the term for this transformation is "Alternative Payment Methodology" defined as "a payment methodology structured such that provider economic incentives, rather than focus on volume of services provided, focus upon: improving quality of care; improving population health; reducing cost of care growth; improving patient experience, and improving access to care." Nationally, states were given the choice to expand Medicaid services and the states that did, are now able to work with the Center for Medicaid Services to implement various pilot programs with the goal of reducing Medicaid spending and eliminating redundancies in care delivery. States who have done this have found, through early pilot programs, that housing is a crucial component in reducing the utilization of those more expensive services within the healthcare system. When Medicaid patients with chronic conditions have stable

housing, their use of emergency department services and nursing homes decreases, while utilization of less expensive primary care services increases.

Several expansion states across the country have made initial investments in supportive housing in order to bolster the ACA's push towards Home and Community Based Services (HCBS). Massachusetts Behavioral Health Partnership has utilized Managed Care and the Section 1115 Waiver to control costs and outcomes for high cost behavioral health patients.^{vii} In many states, including Massachusetts, one of the main objectives of this reform initiative is to use cost effective strategies to grow healthcare savings and reinvest in the community. Specifically targeted to their Medicaid population, New York implemented several initiatives to integrate housing in healthcare services. Using the Health Home State Plan Amendment, New York has made Supportive Housing a mandatory partner in health home networks for populations with mental illness, chronic conditions, and HIV/AIDS. Results of this initiative have shown that several emerging practices are finding ways to integrate housing and health, and pay for case management services essential to stabilizing health.

In a similar way, New York has utilized the State's Section 1115 Medicaid Waiver to aid in the construction of new supportive housing units, as well as to provide subsidies and service support for use in existing units. Under this model, an up-front investment was made by the state through reinvesting early savings from other Medicaid reforms and leveraging existing funds from other sources.^{viii} Federally, Medicaid resources are not used for housing capital development or rental assistance. However, Medicaid resources at the state or local level have the spending flexibility that these types of innovative interventions require.

In Minnesota, Hennepin Health, in partnership with the state, is creating a system that links members to coordinated housing and services.^{ix} Under this model, housing is funded by the state and Hennepin Health works with providers to prioritize care to residents with the highest need for care.

Through this partnership, the county has saved money and has redirected those savings to support their subsidized housing program.

In Connecticut, several initiatives are being implemented using assertive outreach and care coordination to link high-cost, high-need clients with primary care, behavioral healthcare, and supportive or affordable housing. Connecticut Integrated Healthcare and Housing Neighborhoods (CIHHN) is one such program, designed to house and provide patient-centered healthcare to 160 individuals in an effort to integrate housing, care management, and healthcare to improve outcomes while lowering public costs.^x CIHHN is part of continuing efforts to identify and target Medicaid-enrolled high utilizers of health services who are homeless or at risk of homelessness and who have chronic medical conditions including serious mental illness, substance abuse disorders or other chronic medical conditions. In order to identify and target high utilizers, CIHHN cross-references data from Medicaid claims with homeless data in order to locate this population and develop accessible care. Cross-referencing data in this way is known as “hot spotting” and is based on the successful methods of Dr. Jeffrey Brenner from Camden, New Jersey.^{xi}

Another effort toward systems innovation in Connecticut, the Working for Integration, Support and Empowerment (WISE) program, is integrating supportive housing services with a package of services offered under the state’s 1915c Home and Community Based Services Waiver. The target population for the WISE program is people with serious mental illness who have been recently discharged from nursing homes. Connecticut has successfully used Medicaid to provide home-based care management and rehabilitative services connected to subsidized rental apartments for this population.^{xii} The State has been a national leader in aligning State and Federal resources to create and finance supportive housing through a collaborative, interagency approach led by the State Interagency Working Group on Supportive Housing.

With the implementation of the ACA, the U.S. Department of Housing and Urban Development (HUD) created a unique grant opportunity to better meet the needs of those who are homeless, as well as those who are low income and living with HIV/AIDS. This program, called the Housing and Health (H2) Initiative, was designed to sponsor technical assistance that supports states and communities undertaking the systems changes needed to enhance integration and collaboration between housing and healthcare systems.^{xiii} Twenty communities across the country have received technical assistance from HUD through this initiative, one of which is Fairfield County, Connecticut. Fairfield County's H2 Action Plan implementation will align with other related initiatives in Fairfield County and Connecticut, including Connecticut's Frequent Users' Service Enhancement (FUSE) Program and Connecticut's SIM grants implementation work. The Action Plan consists of four goals that address housing, treatment, and supports to create sustainable partnerships across housing and healthcare that facilitate better health and housing outcomes for the target population.^{xiv}

The Center for Medicaid Services does not have a track record of paying for housing or housing subsidies outside of nursing home settings. Reforms that attempt to reduce cost for the high utilizer population are using different streams of funding to cover the upfront costs of housing and are then reinvesting Medicaid savings to expand access to housing or supportive services. Several states are proposing to use the Section 1115 waiver to expand coverage of wraparound services beyond the licensing requirements set by CMS. According to the Center for Health Care Strategies, as much as 85 percent of care management provided in a supportive housing environment is potentially reimbursable under the Medicaid program.^{xv} At this early stage of implementation, each state Medicaid program has different regulations for coverage, making each innovative model of coordinated care unique. Different localities are working on unique ways to blend funding streams and reduce the cost of care for high utilizers of their system.

In a June 2015 informational bulletin, the Center for Medicaid and CHIP Services outlined specifications for coverage of housing-related activities and services for individuals with disabilities.

Within the bulletin, housing-related activities and services are identified as:

individual housing transition services that support an individual's ability to prepare for and transition to housing, individual housing and tenancy sustaining services, and State-level housing-related collaborative activities that are services supporting collaborative efforts across public agencies and the private sector to assist in identifying and securing housing options for individuals with disabilities, older adults needing Long-Term Support Services, and those experiencing chronic homelessness.^{xvi}

CMS is committed to help states expand home and community-based living opportunities consistent with the Affordable Care Act. To that end, information in the bulletin is intended to support states in designing benefit programs that acknowledge the social determinants of health and contribute to a holistic focus on improvement of individual health and wellness.

Beyond State Medicaid reform initiatives, UnitedHealth Group, one of the largest health insurance companies in the country, has been investing in the construction of new affordable and supportive housing across the country. In 2013, UnitedHealth Group invested 50 million dollars into a fund to construct low-income rental housing in Minnesota and the Upper Midwest.^{xvii} In 2014, they provided \$11.7 million in equity to construct the first affordable housing community in downtown Austin, Texas in 45 years.^{xviii} Most recently, the company partnered with the State of New York to construct a housing development in the Bronx that will provide 68 affordable apartments with support services for individuals and families. Throughout the United States, UnitedHealth has provided more than \$230 million to help build and invest in new community developments that offer quality affordable housing with support services to low-income families, individuals, veterans, seniors, and persons with disabilities.^{xix} It is unknown if these investments are specifically aimed at reducing costs of hospitalizations or emergency department use by their highest utilizers through these housing initiatives, but these investments have occurred within the timeline of the Affordable Care Act.

3. METHODOLOGY

3.1 Key Informant Interviews

The purpose of this research study is to understand the implications of the Affordable Care Act on housing in Rhode Island. Qualitative data was collected from key informants through interviews. Key informants consisted of a sample of twenty-six local policy experts from Healthcare, Public Health, and Housing. The initial outreach was conducted through contacts that were already known to HousingWorks RI. Subsequent participants were located through recommendations made by participating key informants and preliminary research. All key informants were Rhode Island based and voluntarily participated in the interview process. Interview questions were designed to gather information regarding current changes in the healthcare system locally, as well as investigating whether or not healthcare and housing providers are working together on policy and practice.

Interviews took place at various locations. Many were conducted at participant's offices, a few were conducted at HousingWorks RI on the Roger Williams University's Metro Campus, and only three were conducted over the phone. All interviews were audio recorded with participants' informed consent. Interviews were then transcribed and coded using NVivo 10. Two significant themes apparent in the data, were the overall impact of the Affordable Care Act in Rhode Island and specific programs locally that participants identified as working across housing and healthcare. Within those two themes, participants spoke frequently of Medicaid, healthcare reform, healthcare dollars funding housing, healthcare expenses and barriers to healthcare and housing agencies working together.

The interview questions asked for information regarding Governor Raimondo's working group for Reinventing Medicaid, as well as the State Innovation Model (SIM) grant. Both initiatives are in developing stages and therefore, work being done has not had an implementation impact. Both initiatives are building committees of healthcare professionals from all sections of the healthcare system. Reinventing Medicaid has several committees of stakeholders led by the Executive Office of Health and

Human Services to try to create quality metrics for hospitals and nursing facilities with the goal to reduce costs in 2016. The SIM grant is primarily a projects and products grant that will be used to create an Integrated Population Health Plan, an Integrated Behavioral Health Plan, and an All Payer Claims Database for Rhode Island. As outlined in the SIM Operational Plan, an Integration and Alignment Project will be implemented to specifically address fragmentation in the healthcare system with the overarching goal of aligning healthcare with other sectors addressing the social and environmental determinants of health. Rhode Island has received \$20 million to implement the SIM initiatives over the next four years.^{xx} At this time, the SIM Steering Committee oversees the SIM grant and SIM staff carry out the day to day functions at each participating state agency. Participating state agencies are: the Executive Office of Health and Human Services (EOHHS), Office of the Health Insurance Commissioner (OHIC), Department of Behavioral Health, Developmental Disabilities, and Hospitals (BHDDH), Department of Health (RIDOH), and HealthSource RI.

3.2 Systems Analysis

In the process of reviewing interview transcripts, it became necessary to conduct subsequent research on the local healthcare system and housing supports system. This research consisted of reviewing government documents, creating system charts, and attending policy meetings. Meetings that were observed for this study included Reinventing Medicaid working groups, 1115 Waiver task force, Money Follows the Person steering committee and MFP Housing working group, the Housing Resources Commission, the Rhode Island Alliance for Healthy Homes, and several public hearings. Attending these meetings gave insight into how housing was talked about within healthcare policy, as well as how healthcare reform was discussed in housing policy. Attending meetings also showed that while healthcare and housing were sometimes discussed, participants in meetings were largely from the same sector; there was very little cross-sector participation unless the meeting was specifically designed to include both sectors, like the Money Follows the Person Housing working group.

Through creating housing supports and healthcare systems charts, a deeper understanding of the two sectors emerged. Looking at these two sectors through funding streams and programs offered, the charts showed healthcare to be a clearly organized system locally and federally, while housing supports are more scattered with different organizations, operating in different ways with less centralized oversight and coordination on a local level. Although the healthcare payment system in Rhode Island was easier to chart, individual providers, hospitals and nursing facilities seem to work in isolation from each other while maintaining relationships with insurance providers and the State. In contrast, the housing agencies appear to have stronger professional relationships across agencies, and work together outside of their organizations on the Housing Resources Commission, the Rhode Island Alliance for Healthy Homes, and on various boards. Overall, the systems analysis worked to fill in the gaps of the data collected in the key informant interviews as well as reinforce the content of that data.

3.3 Professional Network Analysis

To identify patterns of policy discussion and collaboration, HousingWorks RI staff surveyed key stakeholders about their contacts across sectors and conducted a social network analysis. The purpose of social network analysis is to identify structures of relationships or perceived relationships within a given population. Overall, prior scholarship has found that populations characterized by more inter-personal ties have a centralized network, one in which otherwise disconnected individuals are linked by fewer intermediaries, and are more effective at sharing information and mobilizing towards collective goals.

The survey asked stakeholders to identify three types of individuals: those with whom they have recently discussed healthcare policy, those with whom they have recently discussed housing policy, and those who they perceived as working at the intersection of housing and healthcare policy. We asked stakeholders to list up to five individuals of each type, a number that prior analysts have shown lead to higher response rates and more specific answers than either asking informants to list more than five

contacts or providing no cutoff.^{xxi} As not to prejudice stakeholders' responses, we did not provide them a list of other stakeholders or otherwise suggest potential responses to the three questions.

After compiling survey responses, we entered them into the UCINET mapping program. UCINET is a reputable software program which produces a visual representation of social networks using survey data. In the resulting diagrams, squares or “nodes” represent informants or those mentioned by them, with key informants in orange and those mentioned by them in blue. Lines, or ties between nodes, represent mentions within our surveys. In entering survey responses, we did not differentiate between stakeholders who mentioned one another (i.e., reciprocal ties) and those who did not. Therefore, a line between key stakeholders A and B might indicate that A mentioned discussing policy with B, that B mentioned discussing policy with A, or that A and B both mentioned discussing policy with one another. Because UCINET uses a mapping algorithm that minimizes physical distance between nodes with the shortest paths between them, the interpretation of the diagrams is intuitive and straightforward: stakeholders that are linked on the diagram reported collaborating with one another, and those stakeholders that appear physically closer to other stakeholders but are not linked directly have more collaborative intermediaries in common by way of stakeholders that appear physically distant.

Overall, the response rate of our survey was 58%, which means that social network diagrams must be interpreted cautiously. Social network data is notoriously susceptible to error due to missing data because only a few well-connected individuals can greatly transform a network structure. Due to time constraints, we also did not query those mentioned by our key informants, and—had we—it is likely that some of these individuals would have mentioned collaborative relationships linking additional stakeholders together. Nevertheless, we see the social network analysis as but one data source that is broadly consistent with the other analyses we have conducted. In particular, the relative lack of bridging connections between stakeholders in the housing field relative to the healthcare field is consistent with

key informants' reports and with key stakeholder's apparent lack of communication and knowledge about other stakeholders' activities within Rhode Island's housing sector.

4. FINDINGS

4.1 Local Impact of the Affordable Care Act

Across the board, key informants attributed the Affordable Care Act with having the greatest impact in expanding insurance coverage in Rhode Island. Many informants referenced the well-publicized success of HealthSource RI, the State's health insurance exchange, as successfully enrolling residents in insurance plans. In 2013, the number of uninsured Rhode Islanders was 120,460. The following year, Rhode Island expanded Medicaid coverage to all persons at or below 138 percent of the Federal Poverty Level (FPL) and former foster care children up to age 26.^{xxii} During the first two years of enrollment, HealthSource RI reported 98,000 people signed up and of that, 28,000 people signed up for private plans.^{xxiii} Many of those who enrolled in coverage for the first time were healthy, young adults, but a small number were individuals with significant levels of unmet medical needs. The new populations now eligible for Medicaid coverage includes individuals who are homeless or at risk of homelessness, adults being released from the Department of Corrections, and healthy low-income adults that have been uninsured. These new populations pose new challenges for local Managed Care Organizations (MCOs), like Neighborhood Health Plan of Rhode Island (NHPRI).

While almost all of the informants perceived the greater enrollment in health insurance as having a positive impact in Rhode Island, they had a difference of opinion on whether high rates of enrollment lead to greater access to healthcare. According to one informant, "The ACA expands insurance coverage...we have to be really clear that access is not immediately helped by the Affordable Care Act, it's probably made worse because there are more people seeking primary care than had so before," whereas another informant thought that "primary care has advanced in Rhode Island because of some of the laws within the ACA that promoted the concept and philosophy of primary care access, so I would

say that has improved in our state.” With the passage of the ACA, the Community Health Centers in Rhode Island received new federal funding to expand capacity in preparation for the 2014 enrollment period. The ACA increased funding for primary care, provided additional funding for loan repayment for professional training of healthcare providers working with underserved populations, and continued the capital investment in federally qualified health centers that had started with the American Recovery and Reinvestment Act in 2009.^{xxiv}

Overall, the key informants were well versed in the rhetoric of the Affordable Care Act. Phrases like switching from “volume to value” or “quantity to quality” were frequently referenced in describing the goals of healthcare reform under the ACA. Informants largely understood the ACA as attempting to improve health outcomes and lower healthcare costs through a patient-centered approach. It was also understood that the ACA encourages collaboration through incentivizing the creation of Accountable Care Organizations (ACOs), bolstering Managed Care Organizations (MCOs) and coordination of care. Through the restructuring of payment systems and insurance, these new forms of management are designed to reduce redundancies in the system to improve delivery of care. Many key informants referred to these changes as a positive step in shifting the mentality of healthcare professionals and institutions towards population and patient-centered practice. As one informant said in reference to the impact of the new payment structure of ACOs:

A bundled payment for post-acute care actually puts the hospital and nursing home in the position of financially being on the hook for making sure there isn’t waste and the best way to avoid waste is to get the patient healthy and back in their home. Versus the current situation where the incentive has been exactly the opposite: strip the patient of the home and let them get sicker in the hospital and get richer.

For some practitioners and policy makers in healthcare, the ACA is seen as a positive shift in perspective that refocuses healthcare on caring for patients rather than making profits. A few informants however, question how the restructuring under the ACA is different from past Health Maintenance Organization (HMO) models. At least one informant felt that the new payment structures of ACOs

would increase the amount of regulation on the practitioners working directly with patients and decrease the level of care patients received.

On the behavioral health side, some informants fear that ACOs will cause non-Medicaid certified organizations to go out of business. Several informants remarked on Medicaid certification as being necessary for organizations to thrive in the push to coordinate care. In Rhode Island, established behavioral health organizations such as The Providence Center, are joining ACOs and are excited about the potential of new partnerships. Smaller organizations that offer specialized services across behavioral health, homeless supports, and elder care however, are finding the new policies under the ACA problematic. As one key informant stated:

Obamacare is all about market forces and competition, and who's got the biggest array of medical professionals...it is a republican, market oriented, capitalist oriented solution to healthcare because people couldn't accept the single payer ideas. It is very flawed in my opinion because it undermines a more holistic, comprehensive approach to special populations, to HIV, the homeless, the ex-offender, the mentally ill, the developmentally disabled.

The nursing facilities representative and representatives from the developmentally disabled community have echoed the flaws listed by this key informant in meetings discussing new regulations for Long-Term Services and Supports (LTSS) under the Reinventing Medicaid Act. There is resistance to changing the regulations of care for special populations under the ACA's reforms, arguing that the proposed changes will decrease the number of people who receive services, resulting in a lower quality of life.

Many key informants referred to the ACOs forming in Rhode Island. The ACOs that have begun are strategic partnerships across larger healthcare organizations throughout the state. Rhode Island's second largest hospital system, Care New England, has formed an ACO called Integra Community Care Network. Integra is a partnership between Care New England, Medicare, Blue Cross, and The Providence Center. Lifespan and Blue Cross Blue Shield of Rhode Island have collaborated on the state's largest accountable care model. Their three-year program is the largest risk-sharing agreement in

Rhode Island and includes Medicare Advantage and commercially insured patients. This collaboration will work to transform the delivery of care for over 35,000 patients and includes 110 primary care providers with the goals of improving care coordination and quality while containing costs.^{xxv} The Rhode Island Primary Care Physicians Corporation (RIPCPC) and UnitedHealthcare have created an ACO to improve care coordination and provide enhanced health services for more than 15,000 Rhode Island residents enrolled in UnitedHealthcare's employer-sponsored health plans.^{xxvi} In 2012, Coastal Medical, a medical service organization focused on patient-centered primary care, formed Rhode Island's first Shared Savings ACO.^{xxvii} In the first performance year of Coastal Medical's Medicare Shared Savings Program ACO, they were able to save \$7.2 million and outperform their cost benchmark by 5.4 percent. A portion of the savings was reinvested into the organization to cover costs of new services and support continued transformation. The remaining savings, after reinvestment, were distributed among all employees in the company.^{xxviii}

Under the Reinventing Medicaid Act, the Executive Office of Health and Human Services (EOHHS) – the State office that governs the State Medicaid plan – launched a Coordinate Care Pilot that will offer operational support to ACOs. Under this program, ACOs are being called “Accountable Entities” or AEs. Other than Rhode Island, no state is using the term Accountable Entities. AEs are the same as ACOs; they are strategic partnerships amongst provider organizations that are innovating new ways of care delivery. As Deb Florio, an administrator of Rhode Island Medicaid and CHIP, outlined in the December 2015 Waiver Task Force meeting, four AE proposals were submitted in the Pilot's RFP process and all four were approved. Each proposed AE was required to contract with three or more entities. Two of the approved AEs, Integra/The Providence Center and Prospect CharterCARE LLC, are hospital based and two, the Providence Community Health Center and Blackstone Valley Community Health Center, are community based. The oversight of these pilot AEs is conducted by the Medicaid

Managed Care Organizations (MMCOs), Neighborhood Health Plan of Rhode Island and UnitedHealthcare. The oversight of the MMCOs will be administered by EOHHS.

A significant part of the work to transform the healthcare system under the ACA, is the management and analysis of data. The ability to align quality metrics and assess outcomes in all parts of the healthcare system is necessary to produce evidence-based practices. In order to assess the healthcare system in this way, a new technology infrastructure is needed. Being able to assess the success of reform initiatives, as well as identify redundancies and gaps in services, is a central focus of the ACA. Much of the work of the State Innovation Model (SIM) grant committee and the Reinventing Medicaid working groups, is to create the infrastructure to analyze outcomes. To accomplish this, the ACA reforms have a technology upgrade component, attempting to move all systems towards thorough electronic reporting.

One of the largest efforts to execute more efficient data processing, is the Rhode Island Executive Office of Health and Human Services (EOHHS) partnership with the Rhode Island Department of Human Services (DHS), to create an integrated electronic enrollment and eligibility system. The design and testing effort, led by the Medicaid office, is called the Unified Health Infrastructure Project (UHIP) and is part of the Reinventing Medicaid Act. The Rhode Island Health Insurance Exchange, HealthSource RI, was the first phase of this initiative. HealthSource RI is an online application system that can be used by individuals, families, practitioners and small business owners to enroll in health insurance plans under the new eligibility expansion of the ACA. The second phase of UHIP, which is currently in progress, is an integrated system called RI Bridges. RI Bridges will be a comprehensive electronic system that allows service providers across healthcare and human services to enroll patients or clients in health insurance plans as well as other human service benefit programs. According to Anya Rader Wallack, former Director of Medicaid in Rhode Island, RI Bridges will coordinate efforts between EOHHS and DHS in an effort to reduce redundancies throughout both systems.

There are also efforts being made across Medicaid initiatives and insurance plans to cross-reference their patient and client data with the Homeless Management Information System (HMIS). HMIS is a local information technology system that HUD requires all Continuum of Care (CoC) Program grantees to use in order to track the provision of housing and services to homeless individuals, families, and persons at risk of homelessness.^{xxix} The expansion of Medicaid in Rhode Island to include low-income childless adults has made health insurance coverage available to the homeless population. Dr. Eric Hirsch, professor of sociology from Providence College, is the local HMIS expert and has worked on comparing information across HMIS and Medicaid claims for homeless individuals. Within the 2008 study, Hirsch et al. tracked the healthcare expenses of each of the Housing First participants. Results from this research showed the healthcare cost savings of housing those who are homeless. Through examination of these two databases, Dr. Hirsch is able to identify homeless individuals who are high utilizers of the healthcare system and understand their patterns of service utilization throughout the shelter, housing supports system and the healthcare system. This type of data analysis across healthcare, social services, and housing is of particular interest to certain initiatives under Reinventing Medicaid; particularly within Home and Community Based Services (HCBS), Long-Term Care, Behavioral Health, Developmental Disabilities and Substance Abuse populations.

4.2 Medicaid Initiatives and Housing

In Rhode Island, as in many other expansion states, Medicaid reform is a top priority due to the unsustainable expense of the program. One of Governor Raimondo's first initiatives after assuming office was signing an executive order creating the working group to Reinvent Medicaid. The Reinventing Medicaid working group was charged with three goals: (1) improving quality, affordability, and efficiency, (2) eliminating waste, fraud and abuse, and (3) making Rhode Island a leader in healthcare innovation.^{xxx} The working group is made up of twenty-nine practitioners and policy makers from State government, healthcare, business, and nonprofit organizations. The working group created

the Reinventing Medicaid Act of 2015 that identified specific budget items that have the potential for cost savings, as well as areas for growth and innovation. The key initiatives of the Act align with the objectives of the ACA and focus on hospitals and nursing homes, coordinated care pilot programs, and building capacity of MCOs and community-based care.

In Reinventing Medicaid policy meetings, housing is not at the forefront of the agenda, however, within reform initiatives tackling the complex needs of specific populations, housing has been recognized as a critical issue. In June 2015, CMS released an Informational Bulletin to assist States in incorporating supportive services into their Medicaid benefits. In the bulletin, CMS clarifies circumstance under which Medicaid will reimburse for certain housing-related activities for specific populations. According to CMS:

Housing-related activities and services are: (1) Individual Housing Transition Services-services that support an individual's ability to prepare for and transition to housing; (2) Individual Housing & Tenancy Sustaining Services-services that support the individual in being a successful tenant in his/her housing arrangement and thus able to sustain tenancy; and (3) State-level Housing Related Collaborative Activities-services that support collaborative efforts across public agencies and private sector that assist a state in identifying and securing housing options for individuals with disabilities, older adults needing Long-Term Services and Supports (LTSS), and those experiencing chronic homelessness.^{xxxi}

CMS's support of housing related services is a major shift in priorities for Medicaid that aligns with the ACA's goal of reducing the costs of healthcare and increasing the health of the population. Stable and secure housing is known to stabilize chronic health conditions, reduce stress, and allow for better utilization of primary care.

4.2a Home Stabilization Initiative

The State of Rhode Island's Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) has been working on housing stabilization and retention services since 2008. An amendment to the Section 1115 Waiver, proposed in 2008, included a Home Stabilization Initiative. The Home Stabilization amendment was accepted in 2015. EOHHS and BHDDH are currently creating certification standards in partnership with CMS. With the inclusion of

behavioral health services as part of the covered essential benefits under the ACA, there is a strong support within behavioral health to expand housing services within the continuum of health services. Several key informants referenced housing stabilization services, which would offer supportive services to specific populations such as housing placement, finding an apartment, daily living management, medication management and whole care coordination. One informant explained:

When we talked about the expansion and the Affordable Care Act probably four years ago, and I was saying to people we really need to make sure we can get the services that people need, especially in the housing world, to stay housed in the community, because basically if someone is eligible for Medicaid, then they are eligible for doctors, prescriptions, things like that...But without increasing the scope of services to include housing stabilization, then for the special needs populations who actually need supports to live in the community and be housed in the community, it wasn't expanding anything there.

With the acceptance of the Home Stabilization Amendment in 2015, BHDDH is working with Medicaid to create a way to pay for services that will support Rhode Island residents struggling with complex conditions in finding and maintaining their housing. As stated in a draft of the Certification Standards for Home Stabilization Services, "Rhode Island has conducted several pilot programs for vulnerable populations that have proven the cost effectiveness of providing permanent supportive housing to individuals who are cycling through emergency systems or have been unable to leave expensive institutions due to the lack of affordable housing and community-based support services that focus on housing retention." The Home Stabilization services are intended to increase statewide capacity for a broad selection of community-based services needed to keep vulnerable residents in their homes. The EOHHS is developing and administering the guidance on these services that will align with the Home and Community-Based Services (HCBS) quality metrics.

4.2b Money Follows the Person Demonstration Program

In 2011, Rhode Island received a federal grant for a Money Follows the Person (MFP) Demonstration program designed to increase options for elderly and persons with disabilities to receive care in the community.^{xxxii} Moving from twenty-four hours a day, seven days a week care facilities into community-based settings is part of the ACA's goals and in the context of MFP, is referred to as

“rebalancing.” According to one key informant, the ACA has created new interest from the Rhode Island Executive Office of Health and Human Services (EOHHS) to figure out a way to bring funds for housing developers and health plans together to better serve the needs of Medicaid and Medicare-Medicaid Dual Eligible patients. Key informants felt that there is widespread recognition of the healthcare costs savings of keeping people in their homes versus nursing homes or inpatient care. However, once individuals are housed, there is little funding for housing retention services necessary to keep people from returning to institutional care. There is hope that with Home Stabilization Services and partnerships with permanent supportive housing providers, MFP can better achieve rebalancing goals.

One of the major barriers to successfully moving patients from nursing facilities into the community according to the MFP program is the lack of affordable housing. In response to this barrier, MFP has created a Housing working group that works to understand what organizations and community services already exist for the elderly and disabled population. Made up of Long-Term Care representatives, home care nurses, Residential Service Coordinators (RSC), assisted living and housing professionals; the MFP Housing working group is a unique forum where healthcare reform efforts directly intersect with housing professionals. There is a clear disconnect within these meetings between sectors, stemming from a lack of understanding of all the services, sectors, and care that vulnerable individuals engage in throughout the state. There is also a hesitancy to disclose funding sources and opportunities, as at this stage it is very unclear what the benefits and expectations of collaboration or coordination will be.

4.2c Section 811 Project Rental Assistance Program

In alignment with the work being done on the MFP demonstration, the Department of Housing and Urban Development has developed the Section 811 Project Rental Assistance (PRA) program designed to integrate supportive housing and healthcare services for people with disabilities. Rhode

Island Housing in partnership with the State Medicaid's office and the Executive Office of Health and Human Services (EOHHS), received \$5.6 million in 2015 from HUD for a Section 811 demonstration. With this grant, Rhode Island Housing will provide permanent supportive housing for 150 households with "extremely low-income persons with disabilities, many of whom are transitioning out of institutional settings."^{xxxiii} The goal of this initiative is to align Medicaid reform efforts to transition high needs individuals into the community with affordable housing providers. HUD intends to continue to collaborate with the Federal Office of Health and Human Services (HHS) throughout the implementation of Section 811 PRA, through the provision of joint technical assistance to states, and to evaluate the program's success in reducing healthcare costs, institutionalization and homelessness.^{xxxiv}

4.2d Cooperative Agreement to Benefit Homeless Individuals Grant

BHDDH received a Cooperative Agreement to Benefit Homeless Individuals (CABHI) grant from the Substance Abuse and Mental Health Services Administration (SAMSHA) that will provide 5 million dollars, over the next three years, to pay for housing retention services for the chronically homeless and those at risk of homelessness. Medicaid Systems change initiatives that are a part of the CABHI create pathways for homeless service providers to administer housing stabilization services that are billable to Medicaid. The major goal of the CABHI states program is to ensure, through state and local planning and service delivery, that the population of homeless and chronically homeless receive access to sustainable permanent housing, treatment, recovery supports as well as Medicaid or other mainstream benefits. The funds through the CABHI are meant to enhance a statewide plan to ensure sustained partnerships across behavioral health and housing systems.^{xxxv} Key informants working directly with the CABHI grant felt that the language in recent grants in the behavioral health sector represents an overall trend towards encouraging partnerships across health and housing agencies in meeting the needs of vulnerable populations. While the CABHI grant is not specifically tied to the ACA or Reinventing Medicaid, the practitioners and policy makers administering the grant are aligning the

CABHI initiatives with goals set by broader healthcare systems transformation in Rhode Island.

Within the key informant interviews, there was widespread agreement that housing is recognized as a social determinant of health and impacts health outcomes within healthcare reform. However, there were strong opinions as to whether or not there was capacity under the ACA to support healthcare providers in addressing housing. Many stated that the overall goals of the ACA to improve health outcomes and lower healthcare costs allow medical professionals, practitioners and insurance plans to begin to consider housing supports as part of patient care. Others, on the other hand, were skeptical of the ability of the ACA to integrate housing into the continuum of care. They argued that there are many issues to resolve within healthcare alone, leaving little capacity for reform efforts to address housing issues. One informant summarized this debate stating:

I think there are two big silos that are like this: there's a whole bunch of unhealthy housing, there's the ACA's desire, there's the desire of some people within healthcare to use the ACA for prevention, and there's the congresses' action to say that all this preventive stuff is free. But you could have an annual checkup and find that your child has asthma and your house is giving your child asthma. There's nothing you can do about your house through the ACA. So the ACA is all-good at figuring out what the matter is, but it is not focused on the determinants of health that cause the stuff in the beginning.

In the key informant interviews, perspectives on housings' role in healthcare were related to the informant's connection to different sectors. Informants who work within the Behavioral Health sector and with specific populations, such as homeless individuals, substance abuse patients, and the mentally ill, had more experience working with patients housing issues directly than other health sectors. Behavioral health organizations have worked to provide housing for patients prior to the passage of the ACA in Rhode Island. It is recognized within the field of Behavioral Health and Homeless supports that housing clients improves health outcomes and reduces overall cost of care. As one informant stated:

I believe the mental health system has a challenge to reach out to all the CDCs (Community Development Corporations) and supportive housing providers you can because you already understand how housing with supports can reduce use of your 24-7 care facilities.

Beyond the Behavioral Health sector, elder care is another large sector that has traditionally dealt

with housing issues. The ACA has put pressure on traditional elder care to change how this sector operates in its goal to have less people in nursing homes and more people cared for in their own homes; a concept that is commonly referred to in healthcare as “Rebalancing” or “Aging in Place.” The nursing homes and Long-Term Care (LTC) sectors have been resistant to this trend, arguing that Rhode Island does not have the infrastructure in place to offer the necessary care to a growing senior population with complex conditions in the community. As with other Home and Community-Based care efforts, keeping seniors in their homes or in the community, poses the need to confront the lack of affordable housing in Rhode Island as well as the aging housing stock that can be a health hazard if not maintained properly. For seniors specifically, trip and fall hazards are a health liability and many of the homes in Rhode Island are not accessible for aging residents.

4.3 Individual Organizations Working Across Health and Housing

In order for Medicaid reform efforts to be successful in Rhode Island, it is clear that participation and coordination across health plans, health agencies, and housing agencies is necessary. Locally, there are a few organizations that are actively participating in healthcare transformation by bolstering housing supports for their members and clients. Those organizations include, but are not limited to, Neighborhood Health Plan of Rhode Island, The Providence Center, Rhode Island Housing, and the Housing Resources Commission.

4.3a Neighborhood Health Plan of Rhode Island

In interviewing representatives from Neighborhood Health Plan of Rhode Island (NHPRI), there were several examples of the insurance plan addressing housing related issues of their members. NHPRI referred to buying air conditioners and other household items that allow members with specific health conditions to stay in their homes as part of their continuum of services. These efforts are contrary to the general perception throughout the interviews that insurance companies are not interested in housing interventions. Due to the reforms brought by the ACA, NHPRI estimates taking on 30,000 new

members in the first year and a half of the roll out within the expansion population. Understanding the needs and health conditions of this new membership has been a high priority and has altered the way they do business. One significant change is building out a staff of housing specialists and caseworkers that conduct home visits. As one informant stated:

Due to the ACA, our membership has grown significantly. So the volume of housing issues has grown and our interventions towards housing have expanded, but we've always worked to try to manage housing for our membership...We actually have brought on new staff within the medical department to help us with this. We have two housing specialists that work with our members. They do things such as work to ascertain housing, help our members maintain [housing], develop contracts with our members who are close to being evicted due to issues such as hoarding and those kinds of things. And anything we can do to intervene to maintain that housing because we know if they lose that housing, it's that much harder to keep them on.

Housing specialists and case managers' aid members in finding affordable housing and visit members in their homes to determine health triggers that could be contributing to high utilization of healthcare services. NHPRI also built up the capacity of their community outreach workers for the expansion population, stating that they have almost equal clinical staff to community outreach workers for this population. Community outreach workers focus on addressing the social determinants of health for members. However, a major barrier to addressing the needs of this new population for NHPRI is the long waiting lists for affordable housing in Rhode Island, as well as the prevalence of poor housing conditions and hoarding. According to NHPRI, "Hoarding is a condition that goes under the radar, unless you visit a person's home." Hoarding can affect a person's health in significant ways; it can exasperate asthma triggers, lead to infestations of bugs and rodents, or create trip and fall hazards. As per one doctor:

It's almost like there's this whole sector of at-risk housing or unsafe housing, and, yeah, they technically have a home, but the power's been shut off or the toilets don't work or there's a hoarder situation.

4.3b The Providence Center

The Providence Center (TPC), which is one of the largest behavioral health organizations in Rhode Island, is on board locally with ACA reforms in many ways. TPC is a part of the AE called

Integra Community Care Network, a strategic partnership between Care New England, The Providence Center, and many primary care physicians throughout Rhode Island. TPC is a certified Medicaid provider and has assisted patients with housing needs as part of their continuum of care for many years. Their Residential and Housing services consists of group homes, supervised apartments, independent housing, and overseeing housing vouchers that are tied to services. One of their more recent programs is the Home Base program, which serves the chronically homeless and at risk of homelessness through providing services and housing. This program began before the ACA with a Substance Abuse and Mental Health Services Administration (SAMHSA) grant that allowed reimbursement for services. Once the ACA was passed, TPC was able to expand the services to the Home Base program because all of the program participants were eligible for Medicaid coverage. The Home Base program, from the start, was a partnership with Rhode Island Housing in order to provide access to permanent supportive housing. A key informant from TCP referred to the Home Base program as a successful example of collaboration across healthcare and housing. Through this program they saw “reductions in medical debt improve individuals’ ability to access housing and employment as well...so our home base team sees housing as a valuable health service, not just housing.”

The Providence Center also has Community Housing Liaisons that are stationed at seven different Housing Authority buildings. The Community Housing Liaison is on a daily rotation providing care to residents in their homes, which integrates supportive services into the Public Housing Authorities housing units. The Liaison also provides case management services and educational services. The case management offered provides support for residents to be self-sufficient, and maintain their health and financial stability. In addition to Community Housing Liaisons, TPC also has personnel at various housing development properties. These clinicians are on-site to handle emergency situations. Office hours are held in the developments so if residents need emergency care, they only have to go to the first floor of their building, they do not need to be rushed to the emergency department. The on-site

emergency support, according to a key informant, came out of housing developers asking TPC for support in dealing with high needs residents in order to maintain their housing.

4.3c Rhode Island Housing

In many of the policy meetings attended for this study, Rhode Island Housing has been at the table. Rhode Island Housing (RIH) is a local quasi-public housing agency that promotes and finances affordable housing throughout the state. Representatives from RIH participate in the Money Follows the Person Housing working group, the Housing Resources Commission and the Rhode Island Alliance for Healthy Homes. RIH is also partnering directly with the Department of Behavioral Health, Developmental Disabilities, and Hospitals (BHDDH) and EOHHS on the HUD Section 811 Initiative to develop supportive housing. As part of their May 2015 Seasons Partners Review titled, “Rhode Island Housing: Assets and Opportunities,” they recommend exploring creative use of Medicaid dollars to fund services for permanent supportive housing. They also reference efforts in Massachusetts and Connecticut coordinating housing and supportive services with human services agencies, and intend “to determine how the experience in these states could be adapted to Rhode Island.”^{xxxvi} RIH is working towards understanding and partnering with healthcare providers and initiatives, which is a shift in how they do business.

4.3d Housing Resources Commission

Several independent housing agencies from around the state participate in the Housing Resources Commission (HRC). The Housing Resources Commission was created by legislation in 1998 to be the State’s planning and policy agency for housing issues. Its mission is “to ensure that all Rhode Islanders have access to safe and affordable housing.”^{xxxvii} The HRC has had longstanding representation from BHDDH and the Department of Health, including several of the key informants from this study. In attending HRC meetings on the continuum of care, it was clear that the Commission is looking to broaden its membership to include healthcare representatives, specifically EOHHS. There was

recognition that Reinventing Medicaid initiatives are expanding the healthcare services into the realm of housing retention services, and that it was necessary to begin to align standards and financing of housing agencies with the new Medicaid standards. The House of Hope Community Development Corporation and Crossroads RI are two independent housing agencies that are participating in the HRC meetings, as well as the MFP Housing working group and other Medicaid meetings. Both of these organizations offer housing and supports to homeless individuals and families throughout the state. These meetings show an effort to broaden networks across sectors and a willingness to break down sector barriers.

4.4 Public Health Initiatives and Housing

When discussing the intersections of health and housing, many informants referenced local public health initiatives and organizations that they felt were related to the ACA and broader healthcare reform efforts. The most frequently mentioned public health initiatives in the interviews and the professional network survey were: Health Equity Zones (HEZ), Green and Healthy Homes, and the Medical Legal Partnership at Hasbro Children's Hospital. Further research showed that the work of these groups is not directly related to the ACA, however some of these organizations are aligning the language and goals of their work with the objectives of Medicaid reform and the ACA.

4.4a Health Equity Zones

Several informants referenced the Rhode Island Department of Health's community-based initiative throughout the state called Health Equity Zones (HEZ) as an example of intersectional work across health and housing. Health Equity Zones are innovative intervention initiatives that are achieved through partnerships between a community-based organization and a healthcare organization. Funded through grants from the Center for Disease Control (CDC), the HEZ programs work on specific health issues within the immediate community to prevent chronic diseases and address the social determinants of health. A few informants referred to the Central Falls and Pawtucket HEZ as an example of collaboration across healthcare and housing. The Central Falls and Pawtucket HEZ is led by Rhode

Island Local Initiatives Support Corporation (LISC), a prominent community development support corporation that is working to reduce health disparities through their “Building Healthy Neighborhoods” program. This program combines efforts of local healthcare providers and social service providers to address the specific needs of the immediate community.^{xxxviii} Improving the social and environmental conditions of Rhode Island neighborhoods is a central objective of these initiatives over the four-year period of implementation.^{xxxix}

4.4b Healthy Housing Initiatives

The Rhode Island Green and Healthy Homes Initiative (GHHI) was the most frequent organization referenced in the professional network analysis and key informant interviews as working at the intersection of health and housing. GHHI is a national public health non-profit that works with low-income families to assess unhealthy housing conditions and implement whole-house interventions that improve health outcomes. The focus of their work is to improve the delivery of services and ensure the efficient use of resources to reduce lead, asthma and injury in low income housing while improving energy efficiency.^{xl} The mission of the local chapter of GHHI is “to break the link between unhealthy homes and unhealthy families.” A large part of their efforts is coordinating services and resources across housing developers, energy efficiency technicians, and healthcare providers that conduct home visits. According to a key informant from GHHI:

What we do is to help families not be dragged down by the expenses of maintaining a healthy home. A lot of times we will get families that are eligible for weatherization funding to get their house more energy efficient and weatherized, so that reduces their electrical bills, and frees them up to have more funds. And, in theory, then they can spend that money on whatever they need to in terms of their health, education, or whatever their family needs, food.

The work of GHHI is not directly related to Medicaid reform efforts or the ACA, however GHHI has been following the changes to Medicaid in order to understand how their services can fit into the goals of healthcare reform. At a public hearing on proposed changes to Medicaid coverage of Section 1500: Medicaid Long-Term Services and Supports, Betsy Stubblefield Loucks from GHHI spoke in support of

the inclusion of “environmental supports” and encouraged alignment between the new regulations and GHHI’s work. Section 1500 is part of the Medicaid Code of Administrative Rules and refers to the Interim Rule for Long-Term Services and Supports (LTSS). The section outlines regulation for Home and Community Based Services (HCBS) and preventive services for the elderly and developmentally disabled. GHHI submitted, in writing, specific clarifications and modifications to the “Environmental Supports” making the health and financial case for a standardized healthy housing assessment that aligns with their work. The “environmental supports” that Loucks referred to are outlined in the regulation as Environmental Modifications also known as Home Accessibility Adaptations. In the Medicaid regulations, certain modifications to the home of a beneficiary can be made “as necessary to support health, welfare, and safety and enable the beneficiary to function with greater independence at home.”^{xli} GHHI has a vested interest in expanding the LTSS home assessment to include the GHHI assessments including lead, asthma triggers, and energy efficiency.

GHHI is also a key group in the Rhode Island Alliance for Healthy Housing (RIAHH), which is a statewide effort to raise awareness about the cost of unhealthy housing. RIAHH aims to provide cross-sector coordination of education, resources and services among State, City and community-based service organizations. Several key informants mentioned RIAHH as a forum for coordination and collaboration across healthcare and housing. However, the Alliance is largely made up of public health and housing organizations and has little representation from the healthcare sector.

4.4c Social Service Programs Identified as Working on Health and Housing

Within the key informant interviews, the Medical Legal Partnership at Hasbro Children’s Hospital was referred to repeatedly as a local organization working at the intersection of healthcare and housing. The Medical Legal Partnership is a nonprofit organization that works to “integrate attorneys into healthcare settings in order to address the social determinants of health.” According to a key informant, the Partnership offers legal representation and counseling around a variety of topics from

substandard housing, benefits denials, guardianships and family law. The Rhode Island Center for Law and Policy, Roger Williams University School of Law and the Brown Medical School, are the institutional partners in this collaborative effort. While advocacy done through the Medical Legal Partnership crosses the line between healthcare and housing sectors, its work does not directly relate to the ACA and is disconnected from the local efforts to reform healthcare. In interviewing a representative from the Partnership, the ACA and the Medicaid expansion has not affected the population of families that the partnership serves. The families who receive healthcare from the Hasbro primary pediatric clinic were already eligible for Medicaid prior to the 2014 roll out of the expansion. Those clients who were not eligible for Medicaid prior to the expansion are still not eligible for Medicaid due to undocumented status.

In addressing housing and other social determinants, the Partnership reaches out to other organizations that can provide the services or supports that their clients need. The Partnership also helps families fill out forms in order to receive assistance across many different programs. Rhode Island's Parent Information Network (RIPIN) uses a similar referral model that several key informants cited as working on healthcare and housing. RIPIN is a nonprofit social service and advocacy organization that assists individuals, parents and children in achieving their goals for health, education and well-being. They offer a program called RI REACH, which is a helpline to assist individuals and families in choosing a health insurance plan. RI REACH stands for Rhode Island Resource, Education, and Assistance Consumer Helpline. In interviewing representatives from RIPIN, it was clear that they do not regularly address housing issues. They do offer referrals to other agencies if a client asks them for help in regards to housing, but they do not directly offer housing services or supports.

4.4d Accountable Health Communities

In 2016, the Center for Medicare and Medicaid Innovation (CMMI) announced a new \$157 million funding opportunity designed to bridge clinical care and social services. CMS will award 44

cooperative agreements ranging from \$1 million to \$4.5 million to successful applicants in order to implement the Accountable Health Communities model.^{xlii} The Accountable Health Communities (AHC) initiative is meant to support and align with ongoing reforms of the healthcare delivery and payment systems. The AHC initiative identifies “related social needs” in two categories: core needs and supplemental needs. The first core need listed in the guidelines is “housing instability and quality.” The AHC, much like the specifications of the HUD 811 grants, requires applicants to partner with at least one State Medicaid agency, community service provider and clinical delivery site. The goal of this 5-year model is to test whether “systematically identifying and addressing health-related social needs of community dwelling Medicaid and Medicare beneficiaries impacts healthcare quality, utilization, and costs.”^{xliii}

Many organizations in Rhode Island are looking to apply for this initiative and the State Medicaid office has requested that those organizations coordinate and collaborate with the hopes of generating a small number of strong proposals. These organizations include the Department of Community Development for the City of Providence, the Green and Healthy Homes Initiative (GHHI), the RI Department of Health (RIDOH) and the Office of Housing and Community Development (OHCD). Anya Rader Wallack, former Director of Medicaid in Rhode Island, is asking all interested community partners to explain how their proposed projects will align with ongoing activities of Reinventing Medicaid and the SIM grant.

4.5 Barriers to Cross-sector Collaboration

Throughout the key informant interviews, several participants referred to significant challenges that kept practitioners and policy makers from working across sectors. These challenges ranged from the ground level, where primary care physicians were frequently mentioned as not having the time or the resources to address root causes of their patients’ illnesses to the highest level, where administrators of healthcare and housing services may be working with the same population but remain disconnected from

each other. There was frequent mention of informal professional relationships between employees of different organizations, particularly those who worked directly with patients or clients, as a type of collaboration across sectors. However, informants cited significant barriers to cross-sector collaboration in any formal or structural sense. These barriers included organizational resistance to collaborating across sectors, lack of infrastructure to fund cross-sector work, and differences in sector terminology.

4.5a Resistance to Collaboration Across Sectors

In assessing the impact of the Affordable Care Act and its relationship to housing in Rhode Island, three sectors emerged as affected by healthcare reform: Healthcare, Housing and Community Development, and Public Health. Stakeholders within these three sectors have varying knowledge of each other, as well as varied understanding of the ACA. In healthcare alone there are many sectors, and include: Primary Care, Hospitals, Nursing Facilities, Home and Community Based Services, and Long-Term Care. Most of the healthcare sectors are fractured, with little communication between stakeholders. For some key informants, the policy shifts of the ACA are meant to incentivize collaboration and coordination within healthcare and are not meant to go beyond healthcare. As one key informant said:

I think there is an awareness of social determinants of health, basically, within the medical system and healthcare system. What my experience has been is that while there's an awareness those with the resources are somewhat reluctant to go down what they believe is essentially a slippery slope.

There is resistance from some working within healthcare to broaden the scope of issues which healthcare providers and insurers are held responsible for. Within Medicaid meetings on hospital and nursing facility reforms, stakeholders have repeatedly referenced limited capacity to deal with circumstances outside of their walls. While there is a lot of activity towards reducing costs and creating Accountable Entities, there is resistance from individual healthcare sectors and organizations to work together towards the larger systems transformation goals.

For other key informants working in sectors of public health and housing, there is hope that the

ACA will lay the groundwork for collaboration across healthcare and social services to address the upstream causes of the social determinants of health. In theory, the ACA was intended to transform the healthcare system from acute care towards preventive care. While the law does require insurers to pay for preventive care, what “preventive care” is remains controversial and difficult to track. Public health initiatives and housing interventions are seen by practitioners in those sectors as upholding and bolstering the goals of the ACA, in that they address social determinants of health that reduce admissions in emergency departments and can keep people healthy and in the community longer. However, there is no mechanism under the ACA that allows for public health or housing organizations to receive financial incentives if their work accrues savings for hospitals or ACOs.

4.5b Lack of Infrastructure to Fund Cross-sector Work

While the broad impact of the ACA may have initiated alignment in objectives across sectors, there still remains several barriers to formal collaboration. Throughout the key informant interviews, the inflexibility of funding streams was referred to as a major deterrent from collaboration. Informants referenced the necessity for “coordinated,” “blended,” or “braided” funding streams in order to link housing and healthcare services. According to one informant:

Organizations that are going to be really successful in this next generation are going to be the ones that understand how interrelated that is, how interrelated getting a job is, how interrelated housing/stable housing is, and education etc.... Obviously having said that, you’re still going to be limited because it’s not one global pool of money so it’s going to take a lot of partnerships.

As grants and federal funding streams are specifically tied to certain services or populations, organizations that are attempting to provide care in holistic ways struggle to find resources for their clients. Many informants spoke of the importance of informal professional relationships across agencies in being able to meet the needs of their clients or patients.

With the acceptance of Home Stabilization Services by CMS and new regulations from HUD requiring partnerships with healthcare, formal partnerships across healthcare and housing are now encouraged at the federal level. This encouragement does not necessarily come with clear information

on how to partner and fund cross sector work. There is a significant gap between sectors in knowledge of operations and funding, as well as some fear that collaboration will spread funds too thin. Fragmentation within each field adds a layer of complexity where, on an organizational level there may be examples of collaboration, there has not been an overall structure developed to support collaborations. Over the last few years there has been research and technical assistance for the housing field to better understand healthcare and how housing can play a role in bolstering health outcomes. There has not necessarily been the same focus from the healthcare sector in understanding the field of housing. The largest projects locally under the Affordable Care Act, such as the Unified Health Infrastructure Project (UHIP) and Accountable Care Organizations (ACOs), are meant to align healthcare sectors that have traditionally not worked together. That alone is a giant infrastructure overall. As one informant said when addressing housings place in the work of healthcare transformation, “and where does housing fit in? Good question. It may not fit in until things have sorted themselves out.”

4.5c Different Terminology Across Sectors

It is clear from attending policy meetings for both healthcare and housing in Rhode Island, practitioners and advocates use terms and acronyms that are not understood outside of their sector. Many of the same terms and acronyms are used in each sector but have very different meanings. For example, CDC means Center for Disease Control within Healthcare and means Community Development Corporation within housing. “Continuum of Care” is also commonly used by both sectors. “Continuum of Care” within healthcare refers to the delivery of healthcare over a period of time, usually care provided from birth to end of life, which includes healthcare services across all stages of care.^{xliv} Within the housing sector “Continuum of Care (CoC)” refers to the HUD program that provides services and supports to quickly rehouse homeless individuals and families while minimizing the trauma and dislocation caused by homelessness.^{xlv}

Another fundamental difference between sectors is how income eligibility is determined for individuals seeking services. On the healthcare side, income determines eligibility for enrollment in federally subsidized, state-administered Medicaid. Income eligibility for Medicaid is determined by the Federal Poverty Line (FPL) which is a measurement calculated annually by the Department of Health and Human Services (HHS).^{xlvi} The Department of Human Services (DHS), which administers other federally subsidized benefits including food assistance, uses the FPL to determine eligibility as well. On the Housing side, HUD uses Median Family Income (MFI) to determine eligibility for housing assistance and subsidies. MFI is calculated based on percentages of the Area Median Income (AMI), which is calculated using the American Community Survey (ACS) data collected by the United States Census Bureau each year. ACS data is used to inform policy and planning across many sectors including hospitals, schools, housing, businesses, and jobs.^{xlvi}

5. DISCUSSION

Overall, the Affordable Care Act has expanded health insurance coverage to many more Americans and has created new incentive structures to propel healthcare systems transformation. The ACA has also shifted the dialogue around health towards a focus on the patient's preferences, overall population health, and broadening the definition of care. In this shift to patient-centered care policy makers, healthcare administrators and providers are forced to begin to consider the issues that patients confront outside of healthcare institutions—issues that go beyond medical treatment into the realm of social supports and housing.

However, the ACA has not necessarily lead to greater access or better utilization of the healthcare system. Healthcare administrators and providers are still trying to understand the new demographics of those covered by insurance and streamline the path to accessing primary care. Data and technology play a large part in being able to successfully disseminate information and update the healthcare system to better coordinate and evaluate services. While the ACA has created incentives for

providers who are able to lower the cost of healthcare, State Medicaid administrators and the Office of the Health Insurance Commissioner, are aligning efforts to implement larger system reforms. All of the reform efforts are labor intensive and expensive in that they require new training, capacity building, and the restructuring of business models. For some sectors within healthcare, these transformations are embraced as both creating better outcomes for patients and receiving more funds through savings. Many sectors, such as Nursing Homes and Hospitals, are very resistant to these changes.

In Rhode Island, issues of capacity and infrastructure remain a significant barrier to successfully implementing the goals of the ACA. Home and Community Based Services alone ask for a larger and different kind of healthcare workforce that does not exist here on a scale necessary to rebalance the Nursing Home and Hospital populations. Inflexible funding streams exclude organizations that work within local communities from being considered part of the healthcare continuum of care. However, within the Reinventing Medicaid systems transformation, efforts are focused on creating opportunities for coordination of social services and housing services within healthcare. These include the Home Stabilization services, the Money Follows the Person Pilot, and the development of the RI Bridges enrollment system. While Medicaid is moving forward on fulfilling the goals of the ACA, it is unclear how the private sector will advance these goals and if, overall, housing will have a formal place in healthcare transformation.

GLOSSARY

HEALTHCARE

ACA: Affordable Care Act

ACO: Accountable Care Organization

AE: Accountable Entities; a coordinated care pilot program for Medicaid Managed Care Organizations

AHC: Accountable Health Communities; funding opportunity from CMMI to bridge clinical care and social services

BHDDH: RI Department of Behavioral Health, Developmental Disabilities and Hospitals

CDC: Center for Disease Control

CMMI: Center for Medicare and Medicaid Innovation

CMS: Center for Medicare and Medicaid Services

DHS: Department of Human Services

ED: Hospital Emergency Department

EOHHS: RI Executive Office of Health and Human Services

FPL: Federal Poverty Level; a measure of income issued every year by the Department of Health and Human Services

HCBS: Home and Community Based Services

HHS: Federal Office of Health and Human Services

HMO: Health Maintenance Organization

LTC: Long-Term Care

LTSS: Long-Term Services and Supports

MCO: Managed Care Organization

MFP: Money Follows the Person Medicaid Demonstration program

NHPRI: Neighborhood Health Plan of Rhode Island

OHIC: RI Office of the Health Insurance Commissioner

RIDOH: RI Department of Health

SAMSHA: Substance Abuse and Mental Health Services Administration

SIM: State Innovation Model Grant

Social Determinants of Health: the range of personal, social, economic and environmental factors which determine the health status of individuals or populations

UHIP: Unified Health Infrastructure Project; combining online registration across DHS and HealthSource RI

1115 Waiver: (Also known as the “Global Waiver”) the CMS mechanism to allow the State to amend the Medicaid Plan

HOUSING

AMI: Area Median Income; midpoint in the family-income range for a geographical area calculated yearly by HUD

CABHI: Cooperative Agreement to Benefit Homeless Individuals Grant from SAMSHA

CDC: Community Development Corporation

CoC: Continuum of Care Program; a HUD program designed to aid in ending homelessness

GHHI: Green and Healthy Homes Initiative

H2: HUD’s Healthcare and Housing Systems Integration Initiative

HMIS: Homeless Management Information System

Housing First: HUD’s rental assistance program for permanent supportive housing to chronically homeless individuals

HRC: Housing Resources Commission

HUD: Federal Office of Housing and Urban Development

OHCD: RI Office of Housing and Community Development

RIAAH: RI Alliance for Healthy Housing

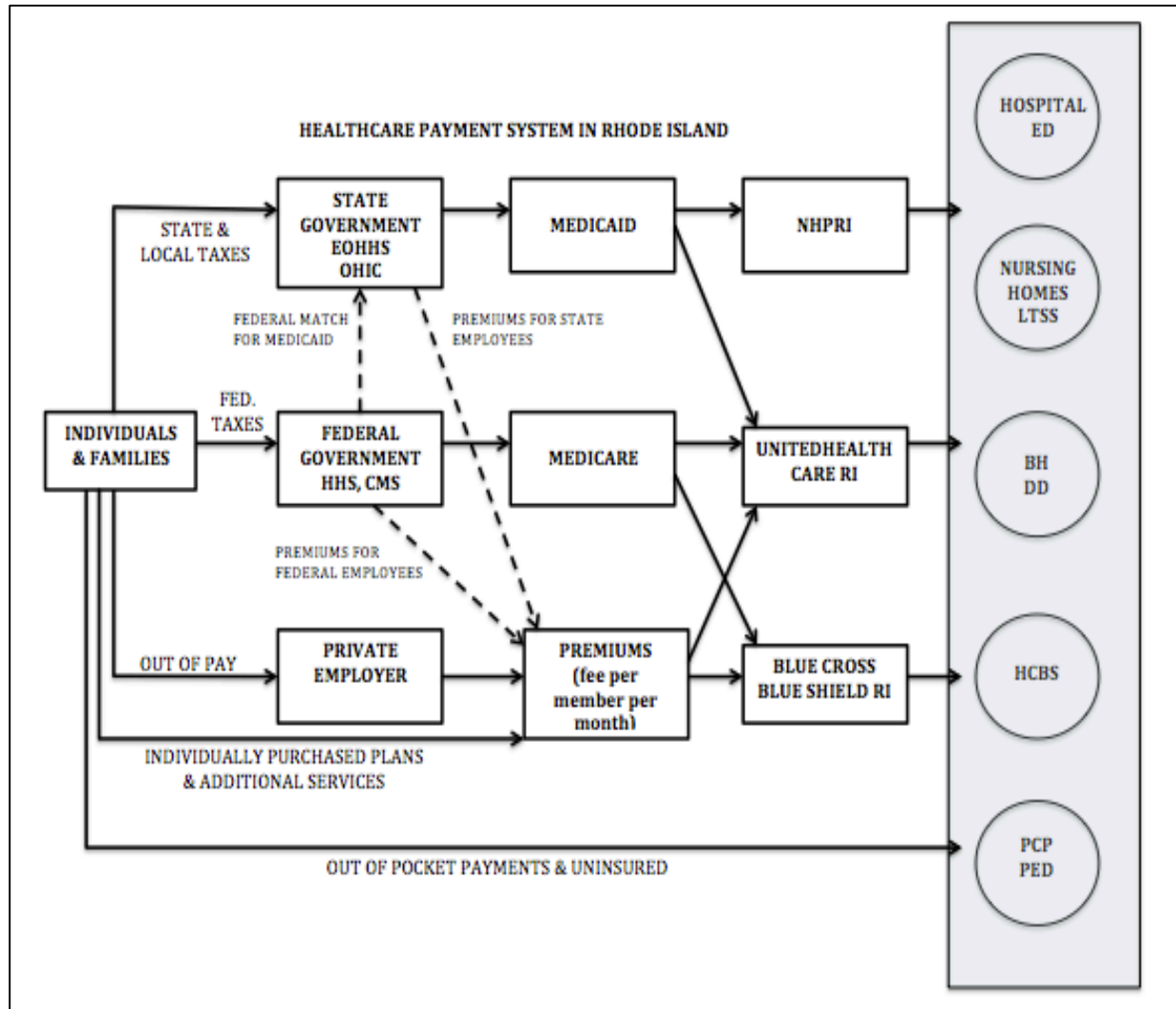
RIH: Rhode Island Housing

Section 811: HUD rental assistance program for permanent supportive housing to persons with disabilities

APPENDIX A

Systems Analysis Charts

I. Healthcare Payment System in Rhode Island

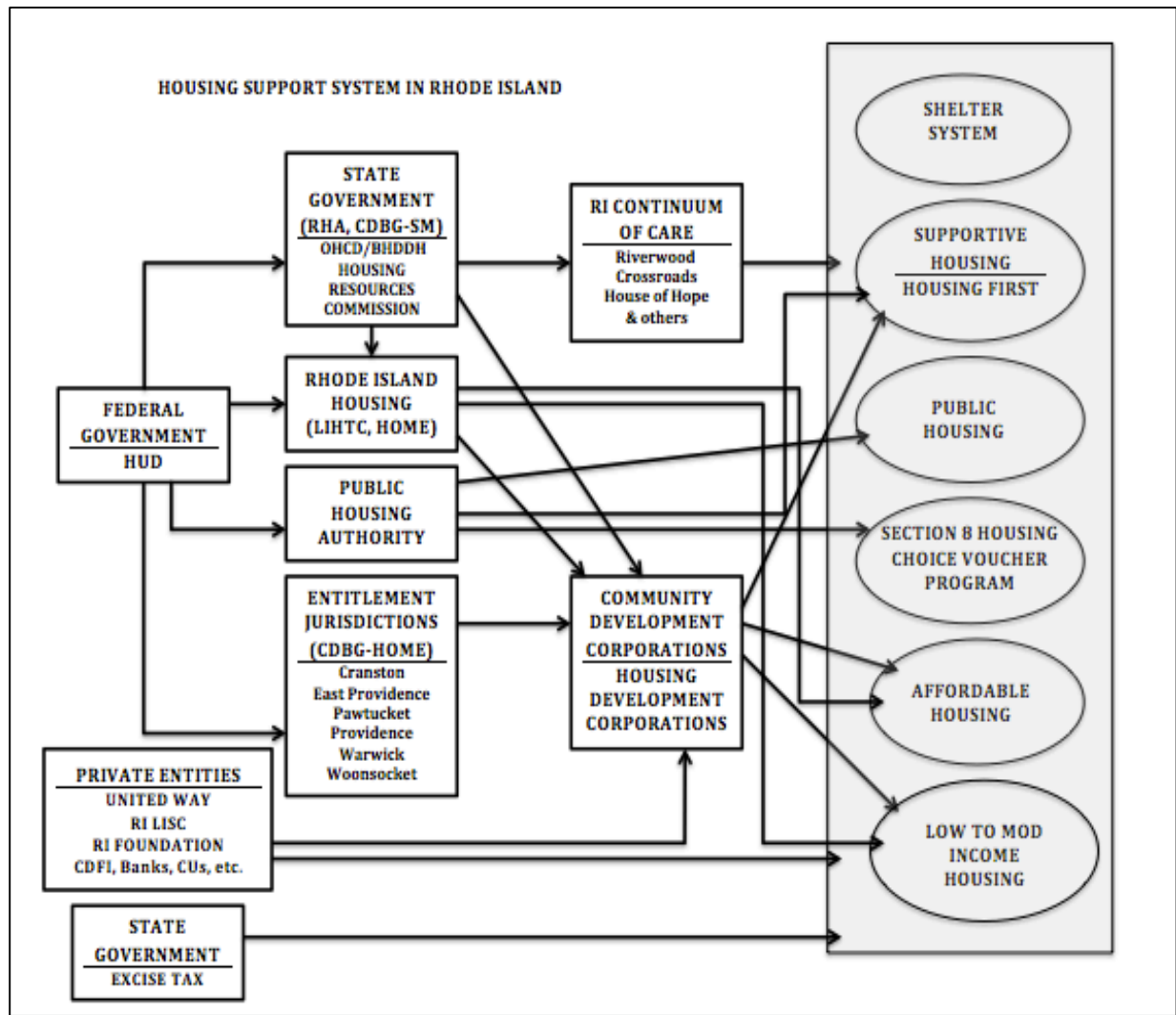


Terms:

EOHHS: RI Executive Office of Health and Human Services
 OHIC: RI Office of the Health Insurance Commissioner
 NHPRI: Neighborhood Health Plan of Rhode Island
 HHS: Federal Office of Health and Human Services
 CMS: Center for Medicare and Medicaid Services

Hospital ED: Hospital Emergency Department
 LTSS: Long-Term Services and Supports
 BH: Behavioral Health
 DD: Developmental Disabilities
 HCBS: Home and Community Based Services
 PCP: Primary Care Provider
 PED: Pediatricians

II. Housing Support System in Rhode Island



Terms:

HUD: Federal Office of Housing and Urban Development

RI LISC: RI Local Initiatives Support Corporation

CDFI: Community Development Financial Institutions

CU: Credit Unions

RHA: Rural Housing Association

CDBG-SM: Community Development Block Grants, Small Cities

OHCD: RI Office of Housing and Community Development

BHDDH: RI Department of Behavioral Health, Developmental Disabilities and Hospitals

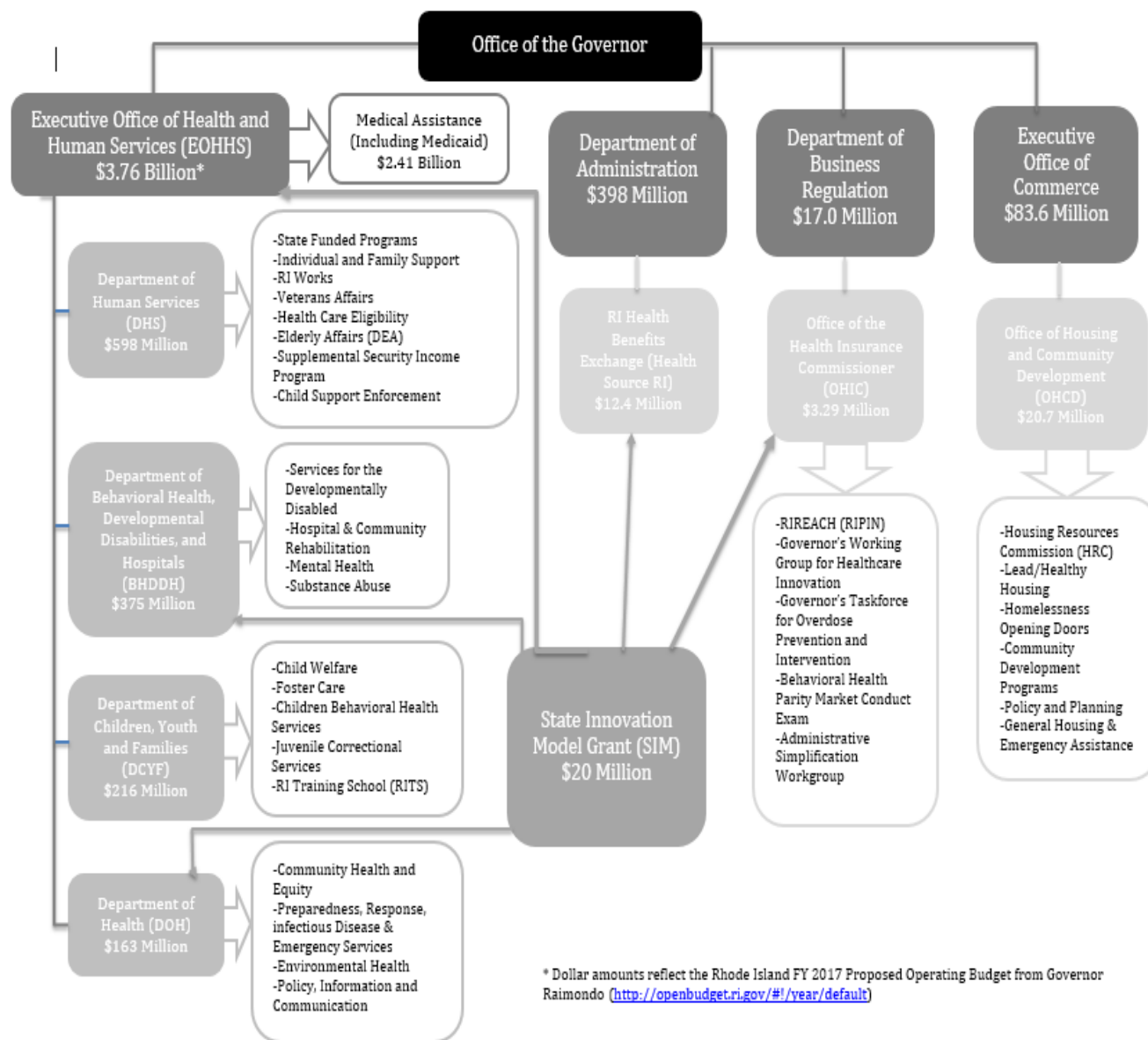
LIHTC: Low Income Housing Tax Credits

HOME: HOME Investment Partnerships Program (HUD)

CDBG: Community Development Block Grants

III. Rhode Island Government Agencies that regulate Healthcare and Housing

RI Government Agencies that regulate Healthcare and Housing



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