Entrenched Opportunity: Medicaid, Health Systems, and Solutions to Homelessness

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Abstract

Context: As inequality grows, politically powerful health care institutions—namely Medicaid and health systems—are increasingly assuming social policy roles, particularly related to solutions to homelessness. Medicaid and health systems regularly interact with persons experiencing homelessness who are high users of emergency health services and who experience frequent loss of or inability to access Medicaid services because of homelessness. This research examines Medicaid and health system responses to homelessness, why they may work to address homelessness, and the mechanisms by which this occurs.

Methods: The authors collected primary data from Medicaid policies and the 100 largest health systems, along with national survey data from local homelessness policy systems, to assess scope and to measure mechanisms and factors influencing decision-making.

Findings: Nearly one third of states have Medicaid waivers targeting homelessness, and more than half of the 100 largest health systems have homelessness mitigation programs. Most Medicaid waivers use local homelessness policy structures as implementing entities. A plurality of health systems rationalizes program existence based on the failure of existing structures.

Conclusions: Entrenched health care institutions may bolster local homelessness policy governance mechanisms and policy efficacy. Reliance on health systems as alternative structures, and implementing entities in Medicaid waivers, may risk shifting homelessness policy governance and retrenchment of existing systems.

Keywords homelessness, Medicaid, health systems, governance, policy development

Millions of Americans experience homelessness annually, including more than 1.3 million school children (NCHE 2022) and more than 1.2 million individuals staying in homeless shelters (Henry et al. 2023: 1–2). Homelessness of any duration exacerbates morbidity and mortality across the life

course (Fazel, Geddes, and Kushel 2014; NASEM 2018). Long-term housing,[1] paired with access to necessary sociomedical services, is the only intervention that successfully ends homelessness (Colburn and Clayton 2022; NASEM 2018). Ending homelessness improves health outcomes and decreases health care costs (NASEM 2018).

Yet in the face of clear solutions, the systems responsible for ending homelessness in the United States—locally organized groups known as Continuums of Care (CoCs), consisting primarily of nonprofit actors—have broadly failed to implement evidence-based responses and reduce or end homelessness (NASEM 2018: 104–5; Willison 2021).

Amid these failures and climbing rates of homelessness, health care actors, including Medicaid and health systems, have become more interested in solutions to homelessness. In recent decades, the role of Medicaid and health systems in addressing the housing needs of people experiencing or at risk of homelessness has expanded. Since the passage of the Affordable Care Act (ACA), policy makers have increasingly proposed that Medicaid and health systems broaden their mission to include targeted responses to homelessness (HHS 2023). This new emphasis on "housing as health care" reflects in part a recognition among policy makers, health system administrators, and advocates that the core US system for addressing homelessness is severely strained.

Compared to CoCs, health care institutions, including Medicaid and health care systems, are durable, entrenched structures in American social and health policy (Grogan 2023; Starr 1982). Health institutions wield significantly more political power and policy capacity than CoCs (Willison 2021). In this way, health care institutions are potentially well positioned to address homelessness.

This study is the first to examine the full scope of Medicaid and major hospital systems' investment in solutions to homelessness. The study investigates *why* health systems and Medicaid may choose to address homelessness; the *mechanisms* by which this work occurs; and the *relationship* between Medicaid and health systems in these efforts. Taken together, our results show that health care institutions are becoming increasingly central players in homelessness policy. Nearly one third of states have Medicaid waivers targeting homelessness, and more than half of the 100 largest health systems have homelessness mitigation programs. Almost half of

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1. The best practice for providing access to long-term housing is known as Housing First, or providing barrier-free access (no behavioral pre-requisites to accessing housing) to long-term or permanent housing (NAESM 2018).

CoCs report benefits from Medicaid despite administrative challenges, and most Medicaid waivers use local homelessness policy structures as implementing entities. Given these findings, health care institutions may bolster local homelessness policy governance mechanisms and policy efficacy. Yet, Medicaid waivers that rely on health systems as implementing entities instead of CoC structures may risk shifting homelessness policy governance and retrenchment of existing systems.

Differential Power Dynamics in Health Care and Homelessness Policy

Any understanding of the engagement of health care institutions in the housing and homelessness policy space must recognize the vast organizational, power, and resource differentials between key actors in the two sectors. Health care institutions are major political stakeholders in the United States. High degrees of political leverage were engendered from long histories of policy engagement from the professionalism of medicine and science (Grogan 2023; Starr 1982). Sustained political leverage for health systems also arises from the ways in which social policy systems have most often been structured around health care, as opposed to welfare or other types of social determinants of health (SDOH) policy (Fox 2016; Lynch and Perera 2017). Following this political development, the greatest amount of government spending on social programs in the United States is for health programs (health care payers and providers), with far less spending on other types of essential social policy for areas such as food, housing, or employment (Gunja, Gumas, and Williams II 2023; Hacker 2002). In this way, the United States is an outlier compared to peer countries because it places a disproportionate emphasis on health care spending and policy compared to the provision of social policy services and structures (Lynch 2019; Tuohy 2018), even though social policies have a far greater effect on health outcomes across the life course (Marmot et al. 2008).

Ultimately, this positions health care institutions as entrenched features in the American political economy, both as policy influencers (Kelly 2023) and as implementers (Michener 2018). Entrenchment refers to a "hard-to-reverse change in constitutive aspects of society and politics" (Starr 2019: 2). As much of health and social policy in the United States revolves around health care, health institutions—especially key payers like Medicaid and powerful providers like health systems—are a defining feature of US policy and politics.

A particularly hard to reverse, constitutive aspect of American health care policy is the delegated discretion to increasingly powerful private actors (Grogan 2023; Starr 2011). A wide body of scholarship has detailed the robust influence wielded by "submerged" or "delegated" state actors responsible for implementing health care policy (Hacker 2002; Mettler 2011; Morgan and Campbell 2011). While nongovernmental actors may not have the same authority as governmental actors, delegated state actors in the health care policy space are often very well resourced. This includes hospital systems and Medicaid managed care organizations (Grogan, this issue). Well-resourced nongovernmental actors retain a high degree of influence in this already entrenched policy space across levels of government.

The actors operating within the homelessness policy domain in the United States are demonstrably different. The actors formally responsible for governing responses to homelessness and designing and delivering homelessness policy in the United States broadly circumvent government (Willison 2021). This primarily nongovernmental system of homelessness policy governance is known as the Continuums of Care or CoCs (HUD 2017; see also the supplemental appendix).

The CoCs are a network of mainly nongovernmental, nonprofit community organizations that receive and distribute federal funding and oversee local and regional homelessness policy programming and service distribution.[2] Importantly, the majority of the CoCs are institutionally not part of or are functionally excluded from local government. Previous research demonstrates that only around 30% of CoCs in the United States are part of municipal government (Jarpe, Mosely, and Smith 2018; Klasa et al. 2021). This unique arrangement has important implications for CoCs as governance mechanisms, and critically, as players in local and subnational political economies.

CoCs have high levels of policy expertise pertaining to homelessness and play an essential role as representatives of the needs of persons experiencing homelessness in local communities, but their policy-making capacity is highly constrained. As nongovernmental, delegated-state entities, CoCs do not have access to and thus cannot use essential policy levers to address homelessness in their local communities (HUD 2017). CoCs are also often excluded from local policy debates about homelessness and thus are also not even able to coordinate policy tasks (Oakley 2002; Willison

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2. A CoC's geographic scope is meant to be local or regional, although boundaries frequently do not overlap with census jurisdictions.

2021). CoCs cannot raise taxes, request intergovernmental transfers to generate revenue, zone, or issue permits for housing or shelter construction. CoCs do not have bureaucratic authority to write local policies pertaining to mitigating and ending homelessness; nor do they have the authority to implement and enforce such policies. Thus, CoCs as primarily nongovernmental organizations often rely on limited funds from the US Department of Housing and Urban Development (HUD) while simultaneously being unable to create the housing and shelter necessary to successfully end homelessness (NASEM 2018: 109). Nongovernmental CoCs function as voluntary systems that operate at the behest of inclusion and support from local governments, should they choose to give it (Willison 2021).

With little to no political influence or policy capacity, the CoCs are *not* an entrenched social policy institution. They are constantly in flux across dimensions ranging from their ability to carry out policy tasks to their very existence (Aykanian 2023; Klasa et al. 2021). However, the functional nature of the delegated homelessness policy governance structure as informal, ineffective, and nondurable or voluntary is very much entrenched. This entrenchment is evidenced by the lack of policy solutions to mitigate and end homelessness by local governments, who rely on CoC nonprofits to manage homelessness while simultaneously undermining their efforts to do so (Einstein and Willison 2022, 2024).

Compared to powerful health care institutions, CoCs function as low-resourced delegated state actors. Limited resource capacity and their nongovernmental status reduces their ability to effectively engage in policy debates, policy making, and implementation. Even in the infrequent cases where CoCs do become part of local government—improving bottom-up engagement in policy-making debates (Michener, this issue) and power over policy tools—they often fail in implementation. Well-resourced coalitions of local economic elites (businesses and wealthy residents) broadly wield more political power than CoCs and generally dismantle evidence-based housing and shelter policies on the ground (Willison 2021).

The leaders of major health care institutions may or may not know about the structure of homelessness policy governance in the United States. Yet these actors are certainly aware of the devastating crisis of homelessness and the increasing challenges homelessness poses for systems, payers, and population health (AHA 2021). The next section reviews conditions that may incentivize powerful players with the ability to act to engage in solutions to homelessness, with consequences for homelessness outcomes and homelessness policy governance itself.

Medicaid and Homelessness

Since its inception, Medicaid has been the primary provider of health insurance coverage for people who are low income and face multiple, complex health risks (Cohen et al. 2015). Today, Medicaid expansion provides health care coverage eligibility to low-income adults, children, pregnant women, elderly adults, and people with disabilities. Before the enactment of the ACA in 2010, eligibility was much more restrictive. People were required to meet income standards and fit within one of the "categories" of covered groups, which generally included children, some of their parents, pregnant women, adults with disabilities, and some adults older than 65 years. Medicaid expansion created a significant opportunity for many people. The ACA expanded Medicaid eligibility to nearly all adults up to 138% of the federal poverty line. This decision effectively eliminated categorical requirements (Cohen et al. 2015).

Medicaid expansion was a game changer for people experiencing homelessness. Medicaid is now the main insurance provider for people experiencing homelessness (ICH 2023). People experiencing homelessness live in poverty, and the majority of people experiencing long-term homelessness have complex medical and behavioral health needs (Augustine and Kushel 2022). People experiencing homelessness who also have a diagnosable behavioral health condition generally qualify for Medicaid because of having disproportionately low incomes and/or through Supplemental Security Income disability benefits (Willison et al. 2021).

Beyond expanded eligibility, there are two types of Medicaid programs with significant implications for homelessness: 1115 waivers and 1915 waivers. Both waivers facilitate improving access to health care and to specialty services typically not covered for people experiencing homelessness, such as housing, permanent supportive housing,[3] and tenancy support.

Section 1115 demonstration waivers allow for reimbursement of costs for housing services. Although the program has existed since 1994 (MAC-PAC 2023), states increased waiver use following Medicaid expansion with the ACA (Gusmano, Sparer, and Brown 2021). In 2021, the Centers for Medicare and Medicaid Services issued guidance encouraging states to apply for waivers to target the SDOH (CMS 2021). With 1115, states

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may test new approaches to Medicaid — such as changes to eligibility, benefits, delivery, and payment systems — that diverge from federal statute. Medicaid reimbursement authorized through a section 1115 waiver generally covers housing services in two categories: (1) direct services related to housing expenses, food access, and legal needs, and (2) capacity-building activities, which tend to include improving the ability of the health care system and social systems to collaborate and deliver social interventions.[4]

Section 1915 waivers allow states to target home and community-based services for individuals enrolled in Medicaid who need additional long-term services and supports (Thompson et al. 2021). States are able to provide "supported living" for Medicaid recipients under these waivers, including services such as meal planning, household cleaning, financial management, and respite care.

In December 2022, the Biden administration outlined new avenues for Medicaid waivers to cover direct housing costs such as rent and funding for housing staffing and organizations, a move unprecedented in Medicaid's history (CMS 2022). Up to 3% of state Medicaid budgets can be directed toward "health-related social needs" services, including housing (CMS 2022; Hinton 2023).

The promise of Medicaid for persons experiencing homelessness has been touted throughout the health policy and health services literature (Bamberger 2016; DiPietro and Klingenmaier 2013). Yet most research has focused on high utilization among Medicaid beneficiaries experiencing homelessness (Cantor et al. 2020; Hollander et al. 2021; Lin et al. 2015; Moulin et al. 2018), with limited research on the scope of Medicaid as a policy mechanism to address homelessness. New research investigating policy implementation finds persistent challenges for Medicaid as a homelessness policy intervention. People who are homeless regularly lose Medicaid coverage (Dapkins and Blecker 2021) as a result of churning incarceration and administrative burdens that do not align with the realities of homelessness, such as annual certification procedures requiring address and identification (Thompson et al. 2021). Frequent forced displacement by police means individuals experiencing homelessness often cannot actually *use* Medicaid; if Medicaid coverage is tied to county jurisdiction, counties must choose to relocate individuals, or hospitals incur uncompensated care (Willison et al. 2021). Finally, Medicaid and CoCs generally do not work together but function as parallel systems with coordination challenges (Thompson et al. 2021; Willison et al. 2021).

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4. Authors' observations.

However, new case study research on Medicaid waivers to address homelessness through care coordination and pretenancy supports suggests that increased interagency coordination across Medicaid agencies, CoCs, and health care partners—facilitated by Medicaid—may improve the success of Medicaid homelessness policy interventions in access to sociomedical services, permanent supportive housing, and health outcomes for persons experiencing homelessness (Pourat et al. 2022: 44; Silberberg, Biederman, and Carmody 2022). There is no research to date on whether Medicaid interventions reduce or mitigate homelessness,[5] but other research has examined the relationship between Medicaid and housing insecurity (rather than homelessness itself) and found Medicaid enrollment had protective benefits against housing insecurity that may buffer against risk of homelessness downstream (Allen et al. 2019; Zewde et al. 2019).

Health Systems and Homelessness

Health systems play essential roles in the daily well-being of people experiencing homelessness. Hospital emergency departments function as primary care providers and shelter because of high rates of untreated chronic medical conditions, constrained access to regular health care, and the consequences of not having safe and reliable shelter or housing for people experiencing homelessness (Treglia et al. 2019). Health systems experience challenges related to bed capacity, staffing, and costs associated with treating health conditions that arise from or are exacerbated by homelessness. This includes infectious diseases, behavioral health, or chronic medical conditions that cannot be successfully managed if persons cannot store medication or have access to water, food, shelter, and hygiene facilities (Bamberger 2016; White, Ellis Jr., and Simpson 2014).

Given these challenges, health services and health care policy scholars are weighing incentives for health systems to address homelessness and the potential effectiveness and ethics (Glied and D'Aunno 2023; Gondi, Beckman, and McWilliams 2020) of health systems as an intervention point. Most of the literature highlights the success of individual case studies of housing and health care programs to improve health outcomes, end homelessness, and reduce costs for hospital systems while also lamenting

5. This is likely because all evaluated Medicaid interventions to date have been unable to pay for housing directly. As the California Whole Person Care waiver evaluation found, "A major issue in addressing housing challenges for enrollees experiencing homelessness was lack of funding to directly provide housing and insufficient housing supply" (Pourat et al. 2022: 43).

failures across multiple systems to successfully address homelessness (Drabo et al. 2021; Hunter et al. 2017; Kuehn 2019; Sandel and Desmond 2017).[6] This literature does not examine the existing CoC system. Furthermore, there is no current sense of the scope of health care interventions to address homelessness, although recent research measures health system investment in addressing housing and other SDOH (Horwitz et al. 2020). Many reviews and investigations of health systems solutions discuss the potential for Medicaid to fund broader interventions to address homelessness (Hawryluk 2019; Reynolds et al. 2019).

Without understanding the scope of health system responses, we cannot begin to measure health systems' influence on homelessness or gauge evolving relationships and policy contexts between health systems and CoCs in local responses to homelessness. Furthermore, with Medicaid as the primary insurance provider for persons experiencing homelessness, alongside increasing federal opportunities to fund responses to homelessness through Medicaid waivers, there may be an incentive for hospitals to engage with Medicaid as a mechanism to address homelessness.

Research Methods

We use a variety of primary qualitative and quantitative data to answer our research questions: assess the scope of Medicaid and health system involvement in responses to homelessness; why health systems and Medicaid may work to address homelessness and the mechanisms by which this work occurs; and the relationship between Medicaid and health systems in their decisions to address homelessness. We collected primary data from a national survey data of local homelessness policy systems, Medicaid policies, and the 100 largest health systems. Following are details of our research design.

National Survey of CoCs—Data and Analyses

During March 2020–January 2021, we surveyed CoCs across the United States and its five major territories. More than 50% of CoCs in the United States were surveyed (n = 225 responded; n = 213 completed), generating a nationally representative sample stratified across types of CoCs and with 47 of 50 states represented (see supplemental appendix). We asked CoCs

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6. Providing housing for people experiencing homelessness reduces high-cost health care utilization, including cycling emergency department use and hospitalization (Williams et al. 2023).

two questions about Medicaid to better understand Medicaid's influence on local responses to homelessness or CoC programming.[7] CoCs' experiences with Medicaid expansion resources for clients (whether through enrollment or billing) provide insight into implementation lessons for Medicaid waivers. These questions were asked as a part of a broader survey of CoC governance structures (Klasa et al. 2021).

We carried out descriptive statistical analyses to identify initial results, including the extent to which CoCs perceived Medicaid expansion to be helpful in their efforts to address homelessness, or not; heterogeneity across regions; and CoC types. We conducted qualitative coding of free-text responses to questions asking respondents about any challenges they experienced with Medicaid expansion (see supplemental appendix).

Primary Policy Data: Medicaid and Health Systems

The Kaiser Family Foundation provides preexisting datasets on Medicaid 1115 waivers, including measures of whether and to what extent waivers include a focus on SDOH (2024). Homelessness is included as one SDOH measure. We collected all currently approved Medicaid 1115 waivers as of August 2023 that include at least one provision targeting homelessness. For many of the waivers, homelessness is the primary focus of the waiver (KFF 2024). In some cases, homelessness is one SDOH provision along with one to three other target categories. After selecting from the Kaiser Family Foundation dataset, each current 1115 waiver was collected from the state Medicaid agency website (see supplemental appendix).

We selected the 100 largest health systems as identified in the *Compendium of US Health Systems, 2018* (ranked beds) compiled by the Agency for Healthcare Research and Quality (2021). While some health systems may be located across multiple states, we selected from the primary site location in the compendium (city/state). Our analysis validates this choice, as all homelessness response programs were in the primary site state, except for two cases where there was an additional location in another state. However, given this selection strategy this is therefore an undercount of health system investments in some cases. To collect health system responses to homelessness, we then reviewed health system websites (July and August 2023). We also conducted a Google search of

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7. Survey question: "Has Medicaid expansion been a valuable resource in supporting access to supportive medical (or other) services for your clients? (Please highlight your selection) Yes; No expansion in my state; Not sure." A limitation of this question is that "No" (i.e., Medicaid expansion has not been a valuable resource) was not an option on the survey. Survey question: "Have you experienced challenges associated with accessing resources for clients and providers from Medicaid expansion? If so, please explain."

"[health system name], [city name of primary site if needed], homeless housing" to capture additional information that may not be cataloged as robustly on health system websites (such as hospital community benefit plans). We only included primary documents from health systems themselves documenting current/ongoing involvement in responses to homelessness.[8] We defined health system homelessness mitigation programs based on: existing response (responses that are targets for the future were excluded); designated system responsibility;[9] and formalization (voluntary programs that do not have formal institutional commitment are excluded). Programs that reference other SDOH that may be relevant to homelessness but do not reference homelessness, housing insecurity, or unhoused were excluded. Two coders using the same search strategies collected primary data, with iterative consensus meetings to improve validity and reliability.

We compiled descriptive statistics of Medicaid waivers and health system policies and programs targeting homelessness across program or policy type (e.g., types of services provided). We then stratified policy presence across relevant factors that may be related to policy or program existence, namely: Medicaid expansion, rates of homelessness (state level) (HUD 2023), partisanship (state level) (NCSL 2024), and system size for health systems (beds and multistate systems, from the compendium).

Finally, we conducted open, qualitative coding across health system policies and programs and Medicaid waivers for emergent themes regarding (1) the rationale(s) for addressing homelessness, and (2) the relationship between Medicaid/health systems and homelessness policy or program existence (as an influential factor in decision-making or reasons for program establishment) or function (regarding programming implementation mechanisms, goals, or output) (see supplemental appendix for details). Two coders were used to establish consensus and enhance measurement validity. Excel software was used to organize, code, and establish intercoder consensus across all primary textual sources.

Results

Overall, our study points to a significant degree of involvement of health care institutions in solutions to homelessness. Nearly one third of states have Medicaid waivers targeting homelessness, and more than half of the 100 largest health systems have homelessness mitigation programs. Most

8. In some cases, news articles linking back to health system sources were included as additional sources.
9. Partnerships are included if the health system has a clear responsibility and/or designated role. A program may also exist in one part of the system and not across the entire system.

Medicaid waivers use local homelessness policy structures as implementing entities. A plurality of health systems rationalize program existence based on the failure of existing structures. We also identify several key challenges that make it difficult for homelessness policy actors to access resources for their clients.

We first present findings of CoCs' relationship with Medicaid to address homelessness, and the scope of Medicaid and health systems' responses to homelessness. We then present qualitative results on why Medicaid and health systems may engage in solutions to homelessness.

Results: CoCs and Medicaid

Our national survey of CoCs shows that nearly half of CoCs (47%) reported that Medicaid expansion has been a valuable resource for their client population. Nearly one third of CoCs (27%) did not have Medicaid expansion in their state, and 25% were unsure.[10] CoCs that were more likely to report Medicaid expansion being a valuable resource in supporting access to supportive medical services for clients were: largely suburban CoCs (57%), regional CoCs (54%), largely rural CoCs (42%), and state CoCs (39%) (fig. 1). Major city CoCs (44%) were more likely to report that there was no Medicaid expansion in their state.

Overall, CoCs reported challenges associated with accessing resources for clients and providers from Medicaid expansion.[11] Across all respondents from states that adopted but had not yet implemented Medicaid expansion, CoCs did not know how Medicaid expansion would affect their operations. In states that recently adopted and implemented Medicaid expansion, the majority of CoCs had not yet seen an increase in access to resources for their clients.

In states that had adopted and implemented Medicaid expansion, CoCs still faced numerous challenges leveraging the program to assist their clients. While most CoCs in this category reported benefiting from expansion by improved access to health care, more than half reported coordination challenges between CoCs, housing providers, and Medicaid agencies. A plurality faced obstacles billing Medicaid for housing services. For

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10. Survey question: "Has Medicaid expansion been a valuable resource in supporting access to supportive medical (or other) services for your clients? (Please highlight your selection) Yes; No expansion in my state; Not sure." A limitation of this question is that "No" (i.e., Medicaid expansion has not been a valuable resource) was not an option on the survey.

11. Survey question: "Have you experienced challenges associated with accessing resources for clients and providers from Medicaid expansion? If so, please explain."
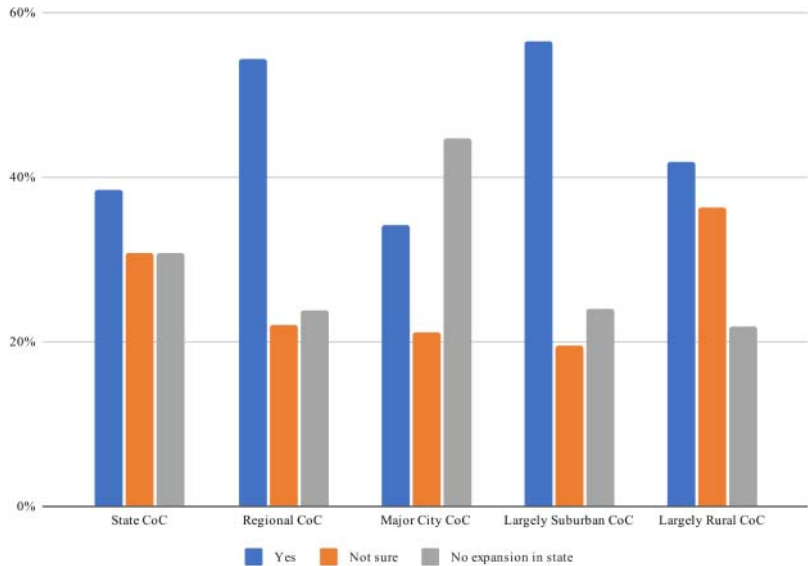
Figure 1   Has Medicaid expansion been a valuable resource for clients?

instance, a CoC in California said they faced challenges related to "billing Medicaid for housing support services for agencies that are not govt affiliated." A CoC in Michigan said, "Most homeless providers have no other reason to become Medicaid billing eligible so it's not practical."

Smaller CoCs noted administrative burdens such as high training and documentation requirements to access resources and qualify to become Medicaid billing eligible. Providers were often unable to bill for services such as case management or housing support. Rural CoCs discussed transportation challenges in reaching medical services that were generally located far away. And in nonexpansion states, CoCs consistently reported a lack of behavioral health specialists serving Medicaid or homeless patients.

Results: Scope of Medicaid Interventions to Address Homelessness

The results of our study show that as of August 2023, 14 states had Medicaid 1115 waivers with provisions specifically targeting homelessness. Six out of 14 waivers involved health care entities as direct components. We define direct components as entities that receive waiver funding and are

responsible for implementing waiver programming (pertaining to homelessness). Health care entities involved in Medicaid waivers include hospitals, institutes of mental disease (MACPAC 2019), behavioral health centers (MHHS 2021: 31), accountable care organizations (CMS 2024), and managed care organizations (MCOs) (Heaton and Tadi 2023). Details and mechanisms of health system involvement compared to other entities are discussed below.

Of these 14 waivers, 12 were in states that had expanded Medicaid. The two waivers in nonexpansion states were in Florida and North Carolina. Importantly, North Carolina approved Medicaid expansion in March 2023, but as of September 2023 the law had yet to be implemented (Robertson 2023).

Of the 14 waivers working to address homelessness, 11 were in states with the greatest prevalence of homelessness (the top two quartiles of state counts of homelessness, delineated as categories of "highest" and "high") (HUD 2023).[12] Three waivers were from states with low counts of homelessness: Vermont, Utah, and Arkansas.

Across the 14 waivers, there were three main categories of interventions to address homelessness: housing, behavioral health and housing, and housing coordination. Housing refers to waivers providing direct housing services (e.g., tenancy support, direct housing subsidies such as 6 months of rent, supportive housing, etc.) through the new 2021 and 2023 programs. Thirteen 1115 waivers provide direct housing support, with two states providing direct housing subsidies (Oregon and Arizona).[13] Housing coordination refers to expanded eligibility of payments for housing navigation and support services that are approved for reimbursement under the waiver. All 14 waivers provide housing coordination support. Behavioral health and housing refers to programs that are providing increased access to housing programs or funding the creation of new housing programs, with eligibility tied to homelessness and a co-occurring behavioral health condition. Nine waivers include behavioral health components.

Results: Scope of Health Systems Interventions to Address Homelessness

Our study found that as of August 2023, slightly more than half of the 100 largest health systems—54 systems—had a formal program designated to addressing homelessness. Large health systems were not more likely to

12. Please see supplemental appendix for figure listing states in each quartile.
13. North Carolina emphasizes housing coordination and only provides direct housing support through a one-time payment of one month of rent.
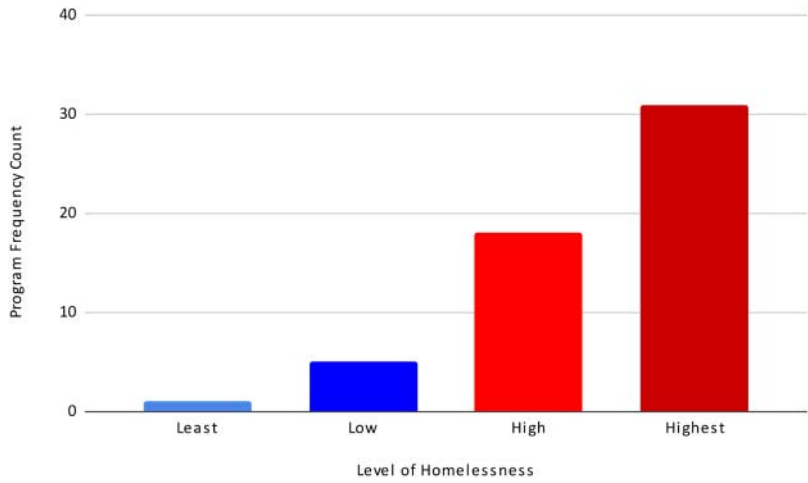
Figure 2   Health system homelessness mitigation programs across quartiles of homelessness prevalence by state.

have a homelessness mitigation program.[14] Programs were nearly twice as likely to be located in Democratic states as in Republican states (see supplemental appendix).

We found a clear relationship between state level of homelessness (as measured by the location of the primary health system location; every homelessness mitigation program is located in the primary system state[15]) and the existence of health system homelessness mitigation programs. Stratified across quartiles of state counts of homelessness, mitigation programs are more likely to be in states with the greatest prevalence of homelessness (fig. 2).

Of the 54 programs, 44 (82%) are located in states with Medicaid expansion as of August 2023 (fig. 3). By comparison, of the 54 systems with homelessness mitigation programs, 19 of them (35%) involve Medicaid as a key part of the program (discussed in detail below). Of the 19 health system homelessness mitigation programs involving Medicaid, 18

14. For bed rankings, each quartile has 14 homelessness mitigation programs, with the exception of the last quartile, which has 12. For program distribution across multistate systems, 17 systems with programs were located across three states, and 17 more systems with programs were located across two states. There were 20 systems with homelessness mitigation programs that were located in one state.

15. In just two cases there is an additional location in another state; thus, we rely on the primary state as the measure.
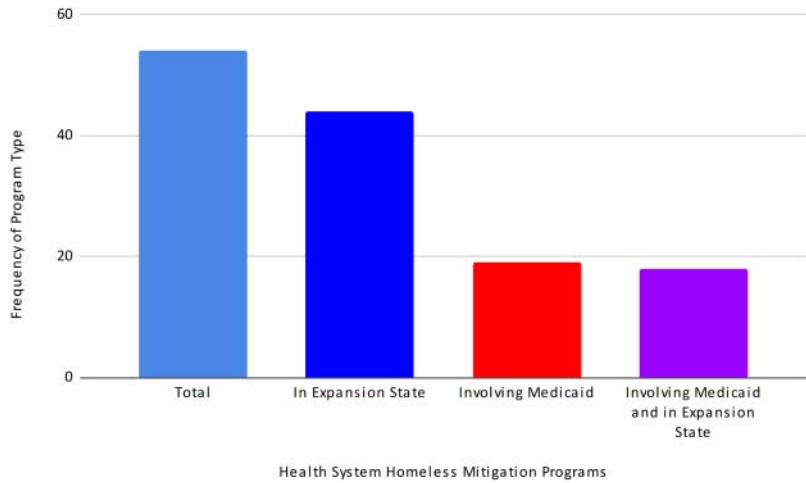
Figure 3 Health system homelessness mitigation programs and Medicaid (100 largest health systems).

are located in Medicaid expansion states (96% of those involving Medicaid; 33% of total).

Finally, there is much heterogeneity in the types of homelessness mitigation programs adopted by health systems. Health system homelessness mitigation programs encompass seven primary types of service categories: shelter medicine, outreach, housing (including affordable housing and permanent supportive housing), shelter and/or temporary housing, medical respite, behavioral health, and service coordination. Housing, shelter medicine, and coordination were the most common types of programs (fig. 4).[16]

Results: Medicaid and Homelessness: Policy Rationale and Mechanisms

All Medicaid waivers were focused on addressing both the costs associated with homelessness and health equity related to high differential needs of persons experiencing homelessness. In these ways, Medicaid waivers framed health equity benefits, such as improved health outcomes or reduced disparities for people experiencing homelessness, as a cost

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16. While hospital program existence was coded as binary, program type is counted across service categories. See supplemental appendix for additional details.
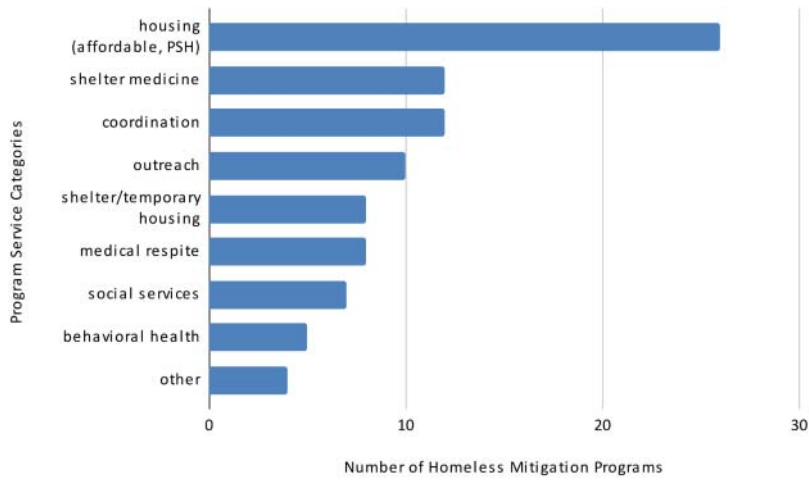
Figure 4 Frequency of service categories across health system homelessness mitigation programs.

savings benefit. "By providing various benefits related to increasing supportive services related to housing, these beneficiaries may have improved health outcomes. . . . Providing these services is also expected to help improve sustainability by decreasing costs" Hawaii's 1115 waiver (Lynch 2019).

Medicaid waivers as a mechanism to address homelessness work through a variety of implementation mechanisms. Implementing entities, who receive waiver funds and are responsible for overseeing and delivering policy components, are key waiver mechanisms. Medicaid waivers targeting homelessness are divided in their use of implementing entities between the existing federal structure of homelessness policy governance—networks of nonprofits—and health systems.[17]

While not referenced in policy goals or rationales for program existence, the preexisting structures for responding to homelessness—networks of nonprofits and/or the formal CoC system—were the most frequent type of implementing entity used by Medicaid waivers to address homelessness (57% of waivers). Waivers using nonprofit networks to deliver waiver services emphasize preexisting expertise and capacity for homelessness-specific services within community-based organizations (CBOs). All waivers using CBOs recognized coordination barriers in CBO service delivery

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17. Maryland, Utah, and Washington 1115 waivers also include local government with CBOs.

and include varying elements of coordination planning. Virginia Department of Medical Assistance Services (VDMAS) in their 1115 waiver highlights the CoC structure and the challenges associated with it: "To deliver high-quality services for High Needs Supports enrollees, DMAS [Department of Medical Assistance Services] will require MCOs to contract with . . . existing providers in the community (i.e., Continuum of Care (CoC) providers) that are experienced and qualified to address the health-related needs of the population. . . . While some of these providers already contract with Medicaid, the majority have limited exposure to [Medicaid Managed Care] and will need initial and ongoing support from DMAS and the MCOs" (VDMAS 2020: 6).

Comparably, six waivers (43%) use health systems as implementing entities. Health systems as implementing entities are either tasked as coordinators to identify service provision and contract out, or to facilitate in-house service provision. In both mechanisms, health systems as implementing entities are framed as overcoming service gaps, while leveraging existing health systems service provision and capacity to improve existing responses to homelessness. The Interim Medicaid Director at Oregon Health Authority in their 1115 waiver describes that "Upstream investment in social determinants of health using health related services . . . allowed CCOs [state managed care organizations] further flexibility to pay for non-medical services that improve health outcomes." The administrator went on to state that "Community-based organizations (CBOs) are chronically under-resourced when compared with health care organizations. . . . Once [CBOs] have developed sufficient infrastructure to assume financial responsibility, they will manage community funds from CCOs to reduce health inequities" (Oregon Health Authority 2022: 34–35).

Results: Health Systems and Homelessness, Program Rationale and Mechanisms

Across all 54 health system homelessness mitigation programs, there was a surprising consistency in the reasons given (as outlined in publicly available documents) for establishing a program. Health systems' rationale for establishing a program center around three key issues: health equity, the homelessness and/or housing crisis, and health systems capacity (spending, beds, etc., pertaining to resource or capacity saving) (see supplemental appendix).

The majority of health system homelessness mitigation programs use equity (55%) as a rationale for program establishment. The health equity

framing highlighted gaps in the health and social service needs for people at risk of or experiencing homelessness that the health system was choosing to fill or had an obligation to, in the context of the differential need. For example, Mount Sinai Health System (2023) announced a $2 million grant to address health equity among birthing homeless and incarcerated women: "The program will focus on providing doula care to pregnant people experiencing housing insecurity or homelessness, and those who are incarcerated, two populations that often face some of the highest health needs and complications."

After health equity, the homelessness and/or housing crisis itself was a clear rationale among a plurality of programs (40%).[18] Programs starkly emphasized how existing systems grossly fail to address the homelessness and/or housing crisis. In this comparison, health systems subsequently describe their duty or responsibility to address the crisis rather than a general difference in health or service needs (equity). Health systems frame their responsibility based on the intersection of the need or severity of the crisis on the one hand, and the failure of existing systems on the other. As the director of housing for Providence St. Joseph Health said, "American cities have been struggling with chronic homelessness for decades. . . . I share others' frustration when I constantly see city leaders pledge to eliminate homelessness, but the problem continues to get worse. . . . At Providence St. Joseph Health, we believe safe and affordable housing is a basic human right. That is why we own and operate supportive housing units for nearly 1,000 low-income residents in California, Washington and Oregon" (Zaricznyj 2018). Of health systems rationalizing the choice to create a homelessness mitigation program in response to the homeless/housing crisis, two thirds contextualized this decision with health equity. An administrator with Cedars-Sinai Los Angeles wrote, "The demand for our expertise and services is rising at unprecedented rates, and we believe it is our responsibility to expand our impact to address the growing homelessness crisis. . . . This health equity grant [given by the health system] will enable us to . . . ensure equity within our organization, among our partners, and throughout the communities and populations we serve" (Cedars-Sinai Medical Center 2022). All health systems contextualizing program decision-making with the homelessness

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18. There were 12 programs citing homelessness as a rationale for program existence, 14 cited housing, and four programs' rationale cited both homelessness and housing, for a total of 22 individual homelessness-mitigation programs rationalizing the homelessness and or housing crisis for their program existence.

and/or housing crisis were located in states with the highest or high levels of homelessness, except for one located in Connecticut.

Nearly one quarter of health systems programs described capacity constraints as a reason for establishing a homelessness mitigation program.[19] Capacity pertained to resource challenges health systems face as a result of the homelessness crisis. Health systems most often discussed limited beds, staffing challenges, and high costs associated with responding to homelessness from a medical perspective alone. Put another way, health systems framed ending homelessness as an incentive for them to successfully reduce system costs and resource constraints. Johns Hopkins describes their collaboration with Baltimore city government and Health Care for the Homeless to provide permanent supportive housing to people experiencing homelessness and reduce health system utilization: "Under the initiative, The Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and other city hospitals will help fund the intensive care and assistance programs that can help prevent a return to homelessness—and likely reduce participants' need for emergency health care" (Burgunder 2019). Nearly one in five (18.5%) mentioned Medicaid as part of their designated policy goals in their efforts to improve capacity constraints, both in reducing Medicaid costs and in using Medicaid as a mechanism to reduce costs.

The mechanisms for program establishment were more consistent than the rationales were. The majority of health systems reported using internal funding as a part of their homelessness mitigation program,[20] most of which came through hospital foundation programs and was related to community health needs assessments. Beyond internal funding, Medicaid was the second most common mechanism described by hospitals as a means of establishing homelessness mitigation programs. One fifth of all health system mitigation programs describe Medicaid as a mechanism for or component of program establishment (e.g., requiring beneficiaries of the program to be enrolled in Medicaid). In some cases, hospitals reported back-filling spending gaps where Medicaid could not cover direct rental payments. For MedStar Health's program, the *Baltimore Banner* (Miller and Cohn 2023) reported, "Medicaid officials have long resisted paying for housing or rent directly, but have warmed to financing other supports that can keep people healthy and able to manage a household. . . . MedStar

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19. A total of 13 out of 54 programs.
20. In some cases funding was not clearly reported in publicly available documents. For these programs, internal staffing is reported, so internal funding is presumed at least in part, but it is not validated further.

Health, which has three hospitals participating in Baltimore, plans to continue funding the ACIS [Assistance in Community Integrative Services] program for now." In all cases where Medicaid is used, Medicaid represents one part of the hospitals' funding strategy for the homelessness mitigation program.

Discussion and Conclusion

Millions of Americans experience homelessness every year (Willison et al. 2023). Reducing homelessness is critical: people who are unhoused experience higher rates of chronic disease, communicable disease, and all-cause mortality compared to housed individuals (Kushel and Moore 2023). Long-term housing, paired with access to necessary sociomedical services, is the only intervention that successfully ends homelessness (NASEM 2018). Ending homelessness improves health outcomes and decreases health care costs (NASEM 2018).

Health care institutions, as durable, entrenched structures in American social and health policy (Grogan 2023; Starr 1982), are seemingly well positioned to address homelessness. Health institutions wield significantly more political power and policy capacity compared to the formal homelessness policy governance structure, which delegates tasks to CoCs, which are low-resourced, locally organized groups of nonprofits (Willison 2021). This study is the first to document and examine the scope of investment by health institutions—Medicaid and major hospital systems—in solutions to homelessness, and why and how these institutions may be engaged.

Health care institutions are involved in homelessness mitigation programs across the country. Our national survey of CoCs shows that almost half reported benefiting from Medicaid expansion through improvements in client access to services, while simultaneously reporting administrative challenges that constrain client access to these new resources. Nearly one third of states have Medicaid waivers targeting homelessness, and more than half of the 100 largest health systems have homelessness mitigation programs. Most Medicaid waivers use local homelessness policy structures as implementing entities. A plurality of health systems rationalize program existence based on the failure of existing structures.

It may be surprising that despite CoCs' reported challenges with Medicaid, the majority of Medicaid waivers use CoC structures as implementing entities. This choice by Medicaid to delegate implementation tasks to CoCs is perhaps even more surprising given the context of CoCs'

limited capacity to carry out their designated policy tasks to end homelessness (NASEM 2018; Willison 2021) and the historical separation between CoCs and Medicaid (Thompson et al. 2021; Willison et al. 2021). However, current Medicaid waivers' selection of CoCs as implementing entities appear to recognize CoCs' valuable policy expertise, even in the face of constrained policy-making capabilities.

The implications of the divide between Medicaid waivers and health systems in their engagement with or criticism of preexisting responses to homelessness are worth discussion. As entrenched systems, Medicaid and health systems have more power, authority, and policy capacity to successfully address homelessness than CoCs do. Medicaid waivers using the preexisting governance structure—CoCs—as an implementing entity may act as a means to bolster CoCs' policy-making positionality by providing them with more resources and funding for staffing, administration, and policy implementation, as explicitly outlined in some current waivers (e.g., Virginia). In such cases, the delegated position of homelessness governance may become more entrenched, thereby improving the authority and capacity of CoCs as better-resourced delegated state actors. If so, this would fill an essential policy gap by strengthening CoCs to successfully carry out designated tasks to mitigate and end homelessness as well as Medicaid interventions to improve health outcomes and reduce homelessness. The California Whole Person Care waiver offers insight into this potential. Local governments and health systems were the implementing bodies in Whole Person Care, yet CoCs still received more resources through partnership arrangements, increasing their ability to design programming and deliver services (Pourat et al. 2022). Finally, entrenching CoCs as effective policy-making structures would likely improve representation of persons experiencing homelessness and their needs in policy debates and decision-making (Michener, this issue).

Alternatively, if Medicaid waivers are unsuccessful in bolstering CoC positionality, we may see a shift away from CoCs as implementing entities and toward health care entities. Given the prominence of health systems programs to address homelessness and their criticisms of preexisting responses to homelessness as a primary reason for engagement, Medicaid decision-making may be influenced by these efforts. If Medicaid responses to homelessness become less engaged with existing governance structures, this may portend policy feedbacks into homelessness policy governance, with further retrenchment of HUD and CoC structures and greater entrenchment of Medicaid and health systems in this social policy space (Campbell, this issue). Such social policy retrenchment would be a major

loss of homelessness policy capacity expertise that health systems do not have, leaving a wide gap to fill with serious consequences for the ability to successfully address homelessness (Glied and D'Aunno 2023).

Ultimately, CoCs may or may not be open to increased policy integration with health care actors. Future research should examine CoC perceptions and preferences about integration with Medicaid and health systems, including benefits and trade-offs. Future research should also evaluate CoCs' and HUD's perceptions or concerns regarding possible threats of retrenchment.

Federal, state, and local policy have allowed CoCs to languish and stymied success in many cases, whether through federal budget cuts or challenges embedded in the local political economy (NASEM 2018). It is clear that an intervention in homelessness policy governance is needed. If Medicaid and health systems skirt around CoCs in their efforts to address homelessness, increasing federal HUD appropriations for CoCs to have sufficient staffing and capacity to become Medicaid billable *and* implement their designated policy tasks would be invaluable but unlikely. Moving forward with cross-sector collaborations, interventions must be approached with caution and a deep awareness of the potential for, and implications of, governance shifts for homelessness policy expertise and representation, and discretion over homelessness policy in general.

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Acknowledgments

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