State Health and Value Strategies
Enhancing Value in Health Care
Support provided by

Robert Wood Johnson Foundation
Improving care for homeless Medicaid beneficiaries

Emerging best practices and recommendations for state purchasers

October 8, 2015
Webinar logistics

- A recording of this presentation, along with the slide deck, will be available next week at http://www.statenetwork.org

- Due to the large number of participants, we will not be able to open the phone lines for questions; please use the Q&A feature instead.
Webinar logistics

To ask a question, make sure that **Q&A** is highlighted blue at the top of your screen. Click it if it is not.

Then, in the bottom-right of the Webex interface, select “All panelists” in the drop-down menu, type your question, and press Send.
RWJF’s
State Health and Value Strategies program

• Supports state efforts to **enhance the quality and value** of health care by improving population health and reforming health care delivery
• **Works directly with states**—including Medicaid agencies, governors’ offices, and more—to promote peer-to-peer learning
• **Connects states with technical assistance experts** to develop tools for new quality improvement and cost management initiatives
• **Collaborates with other funders and stakeholders** to produce issue briefs and host convenings, focusing on best practices for states

To express interest in TA: [http://statenetwork.org/contact/](http://statenetwork.org/contact/)
I. Introductions

II. New issue brief on improving care for Medicaid beneficiaries experiencing homelessness

III. Perspective from state Medicaid agency

IV. Perspective from Medicaid managed care plan

V. Perspective from Medicaid provider

VI. Questions
Introductions

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SHVS Action Brief and Toolkit
Improving Care for Medicaid Beneficiaries Experiencing Homelessness: Emerging Best Practices and Recommendations for State Purchasers

SEPTEMBER 2015

Prepared by Carol Wilkins, MPP

Introduction

Nationwide on a given night in January 2014, more than 578,000 people were homeless, and one third of these people were sleeping on the streets, in cars, or other places not meant for human habitation. Over the course of a year, about 1.42 million people used a shelter or transitional housing program for homeless individuals or families. Homeless people often have significant health and behavioral health needs that can be very difficult to manage without stable housing. Compared to the general U.S. population, adults who are homeless as individuals, or in families with children, are more than twice as likely to have a disability. Older homeless adults often have chronic and disabling health conditions that put them at risk of extended stays in hospitals and nursing homes. People who are chronically homeless often have complex, co-occurring physical disabilities, chronic medical conditions, serious mental illness, significant cognitive impairments, and/or substance use disorders.

Many people who experience homelessness are Medicaid beneficiaries. In states that have expanded Medicaid eligibility as an option under the Affordable Care Act, nearly all adults experiencing homelessness are eligible for Medicaid. In addition, an increasing number of homeless Medicaid beneficiaries are enrolled in managed care plans and other organized delivery systems. Medicaid agencies and their managed care contractors have important roles to play in purchasing health care for people who experience homelessness and improving outcomes for these vulnerable beneficiaries.

What do we know about homeless Medicaid beneficiaries?

- High rates of chronic and disabling health conditions
- Co-occurring behavioral health disorders and cognitive impairments
- Complex needs and barriers to care
- Growing number of older adults
- High costs for avoidable hospitalizations, emergency room visits, crisis services, nursing homes
- Most Medicaid agencies and managed care organizations have limited experience with best practices for serving these beneficiaries
Connecticut Medicaid-HMIS data match

- HMIS data sent to Medicaid agency
- 4,193 single adult Medicaid beneficiaries identified as homeless
- Top 10% (n=419) used $28.5 million in Medicaid services
What is permanent supportive housing?

Affordable rental housing
- Apartments in community settings
- Subsidies to help pay rent
- Housing First – as a foundation for health
- No time limits
- Priority access for the most vulnerable and chronically homeless

Supportive services
- Help to get and keep housing
- Face to face case management
- Frequent visits – outside of clinics
- Relationships build trust, motivate change
- Integrated attention to medical, behavioral health, social needs
Opportunities for Medicaid savings

• Supportive housing significantly reduces the need for costly emergency care and hospitalizations
  BUT

• Medicaid agencies and managed care plans often don’t know how to connect their most high risk homeless members to housing assistance

• Health care and homeless assistance / housing systems speak different languages
Permanent Supportive Housing

Handout #1:

• Basic information for Medicaid agencies, health plans, Medicaid providers
• What is it? How does it work?
• Making connections for Medicaid beneficiaries
  – Who is likely to be prioritized / eligible for supportive housing?
  – Collaborating to care for shared consumers
• Where to learn more
Connecting Medicaid agencies and MCOs to local housing resources

Handout #2: Understanding the Homeless Assistance System
• Continuum of Care – finding partners for collaborative planning and access to housing resources
• Local coordinated entry systems under development
  – Streamlining access to housing assistance
  – Prioritizing the most vulnerable people for supportive housing

Handout #3: Helping Homeless Beneficiaries
• Template for creating a local resource summary for plans and providers to use
Data and Screening Tools

Handout #4:
Screening to Identify Homeless Beneficiaries

- Multiple data sources can help identify homeless Medicaid beneficiaries
  - Homeless status at time of application for benefits
  - Addresses of shelters, clinics, social service agencies
  - Zip codes (XXXXX, YYYYY, 99999, etc.)
- Matching data from Medicaid and Homeless Management Information Systems (HMIS)
- Screening for homelessness or risk (VA Medical Centers)
Who gets priority for housing?

- HUD guidance encourages prioritizing most vulnerable and chronically homeless people for supportive housing
  - Can align with eligibility for Medicaid services, if not limited to specific type of disability
- Standardized assessment tools for coordinated entry to supportive housing and other assistance
  - VI-SPDAT is one example, widely used
- Identify characteristics of high-cost homeless Medicaid beneficiaries and design services for them
  - Use data to identify homeless people who are “frequent users” and connect them to housing
Innovations to control costs and improve care

- Medicaid health plans and hospitals partnering and contracting with community providers
  - Intensive case management linked to housing assistance
  - Services in supportive housing
  - Multi-disciplinary teams
  - Medical respite (recuperative care)
  - Housing navigators

- Pilot programs provide evidence of savings and better outcomes for members
  - Making the case for sustaining and expanding
Medicaid purchasing strategies

• Create opportunities and incentives for health plans and Medicaid providers to link services with housing
  – Quality measures related to reducing avoidable emergency room visits and hospital readmissions
  – Requirements to engage and develop care plans for high-risk members
  – Flexibility to fund new types of service providers
• Requirements for plans to collaborate with interagency partnerships and housing initiatives
• Recognize the costs of innovative approaches to serving homeless members as health care and quality improvement initiatives – not administration
Medicaid policy or coverage changes to consider

• Adapt benefits that cover flexible, mobile mental health services (ACT, Community Support) to reach other beneficiaries with complex needs
  – Cognitive impairments, substance use disorders
• Give health plans flexibility to offer services that are appropriate, cost-effective substitutes for state plan benefits
• Use waivers to cover “diversionary” services and test new approaches to financing services linked to housing
Whole Person Care: Transforming Health Care and Housing Services in California

Hannah Katch, Assistant Deputy Director
Health Care Delivery Systems
California Department of Health Care Services

October 8, 2015
Whole Person Care:
Transforming Health Care and Housing Services in California

1. Medi-Cal 2020: California’s 1115 waiver renewal

2. ACA Section 2703 Health Homes & Housing

3. California Community Transitions
1. Medi-Cal 2020: California’s 1115 waiver renewal

**Vision for 2020**

- Continue to build capacity in ways that better coordinate care and align incentives around Medi-Cal beneficiaries to improve health outcomes and reduce disparities, while also containing health care costs.

- Bring together state and federal partners, county systems, plans and providers, and safety net programs to share accountability for beneficiaries’ health outcomes.
1. Medi-Cal 2020: California’s 1115 waiver renewal

Housing & Supportive Services

Potential target populations: high-utilizers, nursing facility discharges; those experiencing or at risk for homelessness

Provide funding for housing-based care management/tenancy supports (outreach and engagement, housing search assistance, crisis intervention, application assistance for housing and benefits, etc.)

Allow health plans flexibility to provide non-traditional Medicaid services (discharge planning, creating care plan, coordination with primary, behavioral health and social services, etc.)

Allow plan contribution of funding to shared savings pool with county partners that could be used to fund respite care, housing subsidies, additional housing-based case management

Allow for health plans and counties to form regional integrated care partnership pilot programs leveraging the range of existing local, state and federal resources in a targeted approach
1. Medi-Cal 2020: California’s 1115 waiver renewal

Regional Integrated Whole-Person Care Pilots

Opportunity for geographic partnerships of state, local, and provider entities

- Medi-Cal Plans
- County behavioral health systems
- Other medical providers
- Doctors/Clinics
- Hospitals
- Non-medical workforce
- Public Health
- Social Services
- Housing
2. ACA Section 2703 Health Homes & Housing

Section 2703 of the Affordable Care Act defines a “health home” as a virtual home that provides enhanced care coordination and other supportive services to address a beneficiary's needs in a holistic way.

A.B. 361 authorizes CA to create a “Medi-Cal health home benefit.” Include among target populations beneficiaries who are—

FREQUENT HOSPITAL USERS

and

CHRONICALLY HOMELESS PEOPLE
2. ACA Section 2703 Health Homes & Housing

• ACA Section 2703
  o Six care coordination services: Comprehensive care management, Care coordination, Health promotion, Comprehensive transitional care, Individual and family supports, and Referral to community and social services
  o 90% federal funding for eight quarters, and 50% thereafter

• AB 361 – enacted in 2013
  o Requires inclusion of a specific target population of frequent utilizers and those experiencing homelessness
2. ACA Section 2703 Health Homes & Housing

• California’s Health Homes Program will:
  o Provide services to the highest 3-5 percent of Medi-Cal beneficiaries through their Medicaid Managed Care Plan
  o Tier the services provided based on the beneficiary’s risk and acuity
  o Phase implementation by county readiness, beginning in 2016
  o Ensure housing supportive services are available to those who are experiencing or at risk of experiencing homelessness
  o Dovetail with Medi-Cal 2020 housing strategies
3. California Community Transitions

➤ CCT Overview

- CA receives federal grant funding to implement a Money Follows the Person (MFP) Rebalancing Demonstration, known in the state as “California Community Transitions” (CCT).

- The primary goal of CCT is to reduce the number of Medi-Cal recipients receiving long-term care (≥ 90 days) in inpatient facilities by arranging for the use of home and community-based (HCB) services.

- Local care coordination organizations work directly with willing and eligible individuals to transition them back home or to the community.

- CCT Project services are funded through Sept. 30, 2016 with the option of extending through Sept. 30, 2020 with CMS approval of Sustainability Plan.
3. California Community Transitions

- 1-year CCT Post-Transition Status

- *Other includes those who lost Medi-Cal eligibility, moved out of the state, etc.
3. California Community Transitions

HUD Section 811 Grants

2012 Section 811 CMS-HUD Project Rental Assistance
• California was awarded $12 million in Rental Assistance which will fund 250 units
• Target population: Medi-Cal beneficiaries age 18-61 who have been in an institution for 90 or more days, and desire to move back into the community

2013 Section 811 CMS-HUD Project Rental Assistance
• California was awarded another $12 million in Rental Assistance for 280 units, in the County of Los Angeles.
• This has been matched by the Housing Authority for the City of Los Angeles for an additional 100 Section 8 housing vouchers and the Housing Authority for the County of Los Angeles for an additional 50 Section 8 vouchers.
• Target population: Medi-Cal beneficiaries residing in skilled nursing facilities, homeless Medi-Cal beneficiaries meeting criteria for super utilizers of emergency and inpatient departments and beneficiaries at risk for homelessness or nursing home placement.
Medicaid Managed Care Plan
United Healthcare
Robert Wood Johnson Foundation
State Health and Value Strategies Webinar
Catherine Anderson, VP State Programs
UnitedHealthcare Community & State
Triple Aim: A Win-Win-Win

States, Members and Health Plans benefit when members:

• Are engaged in their health
• Experience improved health outcomes
• Establish relationships with their primary care doctor
• Utilize the right health care services in the right setting at the right time
• Live and receive services in the least restrictive setting

Source: UnitedHealthcare & Corporation for Supportive Housing Housing and Healthcare Webinar Series
One of the most significant challenges faced by complex populations eligible for Medicaid is the availability of stable, appropriate, and affordable housing.

Housing stabilization can be an important element to reducing health system costs for individuals with behavioral health conditions and/or chronic illness.
Housing & Healthcare

A Continuum Of Opportunity

- Engaging and Connecting Individuals Who are Homeless With Health Care Services
- Connect Individuals to Existing Housing Resources and Entities
- Coordinate Between Health Plan Staff and Housing and Housing Service Providers
- Leveraging Existing or Emerging Medicaid Benefits to Support Housing
- Identifying Innovative New Ways to Address Housing Challenges
Evaluating Opportunities

- Countless opportunities to improve the link between housing and health care exist
- Limitations on what Medicaid can pay for and how health plans can account for the spending related to housing significantly impacts decisions to pursue
- When we evaluate a housing related opportunity within our health plans we consider many factors including:
  - Number of members impacted
  - Opportunity to improve quality
  - Opportunity to improve utilization
  - Data available to support the decision to invest
  - Presence of trusted partners
Case Study: Texas Chronically Homeless Initiative

The Vision

To develop robust partnerships with homeless coalitions in areas with high numbers of unable to locate, likely chronically homeless, individuals with high health care utilization. Leverage partners’ tools and capabilities to locate these individuals, facilitate rapid supportive housing placement, and engage the managed care coordination team to wrap around Medicaid support services.

Our Partners

- Continuum of Care Program Providers

Build Relationships Among Partners

Establish Parameters

Contract

Data Match

Begin Locating and Engaging Members

Facilitate Housing

Facilitate Health Care Access

On-going Support

Measure and Evaluate

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Opportunities for States

States play a significant role in developing an environment that encourages health plans to invest in innovative solutions around housing.

Examples of key program design considerations include:

- Execute Medicaid expansion or an alternative to get individuals covered
- Consider housing related services within Medicaid waivers
- Integrated benefit design – physical, behavioral, state plan and waiver benefits
Opportunities for States

Examples of key contract related considerations include:

• Recognition of investments to improve quality versus administrative costs

• Rate setting that doesn’t penalize investments that result in decreased utilization

• Culture to support innovation, testing, re-evaluation and re-tooling – not all pilots will be successful, flexibility is needed

• Paths for contracting with non-traditional Medicaid providers

• Flexibility to foster collaborations that leverage organizational strengths not pre-defined partnership entities
Medicaid Provider
RWJF State Health Value Strategies
Guild Incorporated & Hearth Connection
Medica Project

Julie Grothe
Director, Delancey Services
About Guild Incorporated

• A not-for-profit organization with a simple mission - We exist to help people with mental illness lead quality lives.

• We offer an array of recovery-focused, intensive outpatient treatment and rehabilitation services

• Many are CARF Accredited

• An enrolled provider with many MN Healthcare plans

Voices of Recovery Wordle:
Clients, family, volunteers, and staff told us what Recovery means to them
Guild Incorporated & Partners

- Guild is a direct service partner with Hearth Connection, an intermediary that develops and manages housing resources for scattered-site Permanent Supportive Housing.

- Medica, a MCO, contracts with Hearth Connection who contracts with Guild to provide a variety of services in support of housing stability and optimal health.

- Guild also contracts with Medica to provide mental health benefits in the MA benefit set to eligible folks.
Who Is Served

• **Gender**
  - 48% Male
  - 52% Female

• **Race**
  - 52% White
  - 30% African American
  - 17% Native American
  - 1% Asian

• **Age**
  - 17% 30-39 years old
  - 74% 40-60 years old
  - 17% 60 and over

• **Constellation of Issues**
  - 89% Chronic Health Conditions
  - 15% Developmental Disability
  - 70% Dual Diagnosis
  - 33% TBI
Our Team Process

**Engage** – Find referred person, begin to engage in services

**Connect** – assess needs and connect to services

**House** – Apply for housing subsidies, look for housing, move in

**Serve** – meet regularly, address ongoing needs
Highlights of the Contract

• Health plan pays one month's service fee for finding and engaging participants

• Health plan uses their internal data analytics capacity to identify high-risk, homeless members and Guild finds them (folks who are "under the radar" of the homeless "system")

• Once located, health plan's "bridge" service funding gives time to access ongoing, mainstream resources
Lessons Learned

• Existing relationship with health plan very helpful; health plan and Guild have mutual goals

• Clear role definition is essential

• Need to integrate with local coordinated entry

• This braided funding model is complex

• Need forum (and trust) to work through issues, as well as share and celebrate successes
Resources: Medicaid and supportive housing

CMS Informational Bulletin (June 2015)

HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE)

- Medicaid and Permanent Supportive Housing for Chronically Homeless Individuals: Emerging Practices from the Field
- A Primer on Using Medicaid for People Experiencing Chronic Homelessness and Tenants in Permanent Supportive Housing
Questions?

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