Stakeholder Planning Advisory Committee

March 6th, 2019

www.iCareHealthPlan.org

Forum Emcee

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INDEPENDENT CARE HEALTH PLAN

Welcome and Introduction

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INDEPENDENT CARE HEALTH PLAN

Presentation: Medicaid Policy and Homelessness

Leah Ramirez

Homelessness Services Policy Manager

Wisconsin Department of Health Services

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WISCONSIN DEPARTMENT of HEALTH SERVICES

iCare INDEPENDENT CARE HEALTH PLAN

A Perspective on Medicaid Services for the Homeless

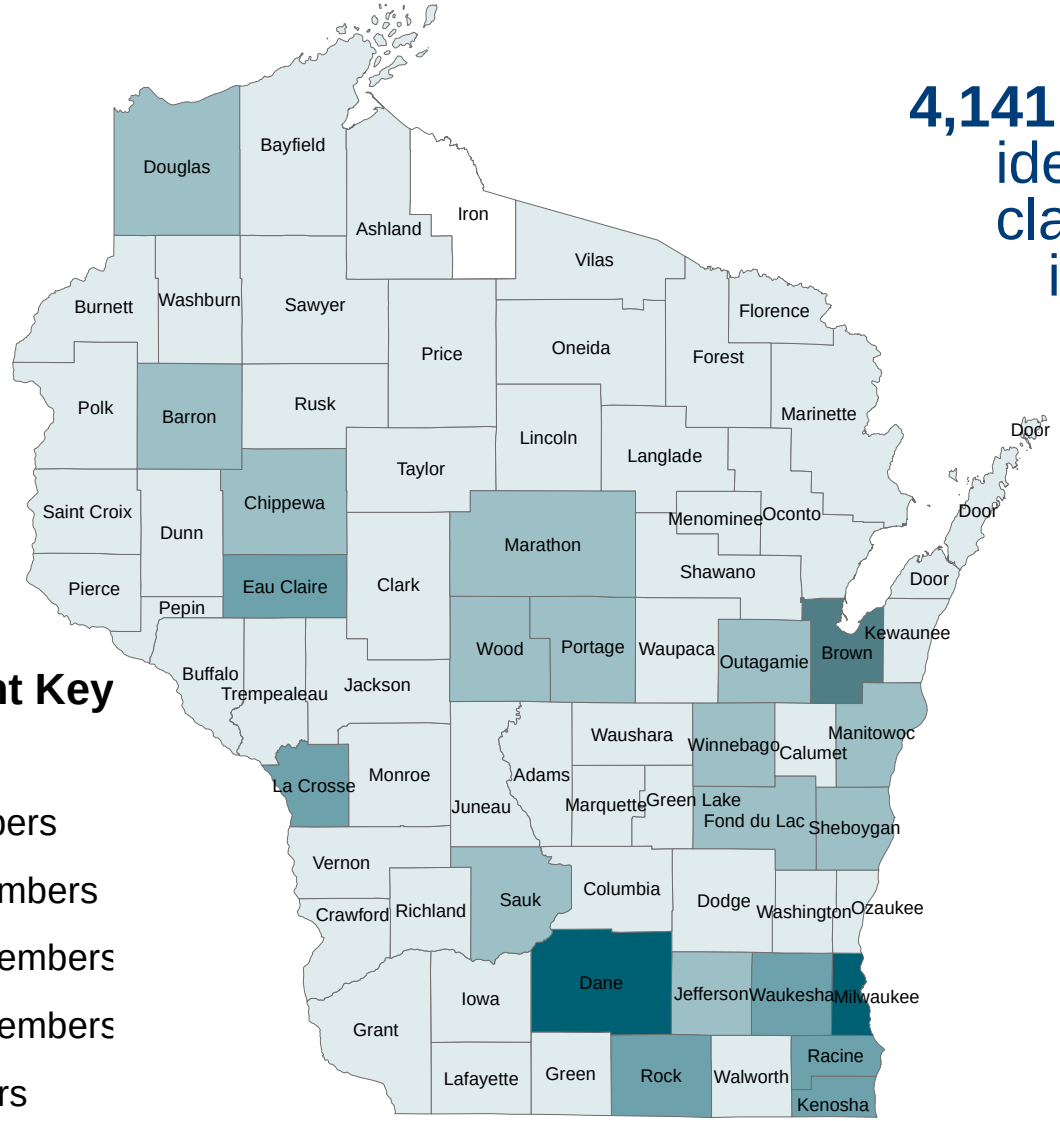
Leah Ramirez, M.S.
Homelessness Services Policy Manager
March 6, 2019

Agenda

- Homelessness overview
- Intersection of housing and health
- Medicaid coverage of housing-related services
- Social needs screening
- Additional efforts

Homelessness Overview

Homelessness in Medicaid



4,141 individuals identified in claims data in 2018

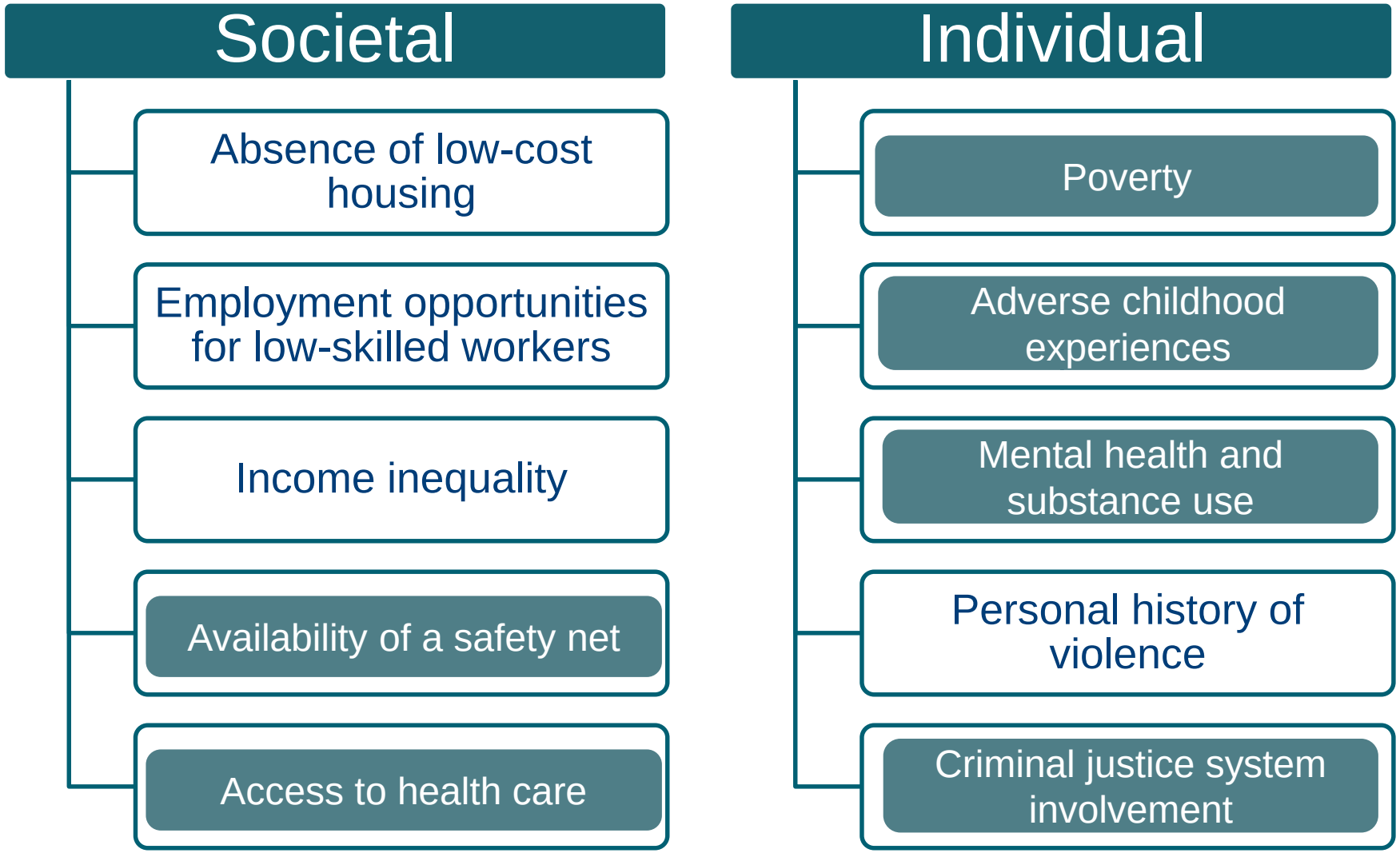
Member Gradient Key

- 0 members
- 1 to 25 members
- 26 to 100 members
- 100 to 300 members
- 301 to 600 members
- 600+ members

Secondary Risk Factors

- Poor nutrition
- Exposure to communicable diseases
- Harsh living environments
- Unintentional injuries
- Higher tobacco use
- Poor access to health care
- Lower adherence to medication

Contributing Factors



Intersection of Housing and Health

Permanent Supportive Housing: Housing First

- Permanent supportive housing (PSH) provides long-term rental assistance and supportive services.
- Housing First does not require people to participate in support services.
- Support services may include:
  - Substance use treatment.
  - Case management.
  - Mental health treatment.
  - Employment training programs.

Utilization and Outcomes

- Improved mental health
- Reduced substance use
- Higher survival rates among individuals with HIV/AIDS
- Reduced emergency room use
- Reduced inpatient hospital

- Housing has generated hospital cost offsets of up to **$42,828** per person per year
- Supportive housing has been shown to reduce overall health care costs by **59%**

Federal Attention

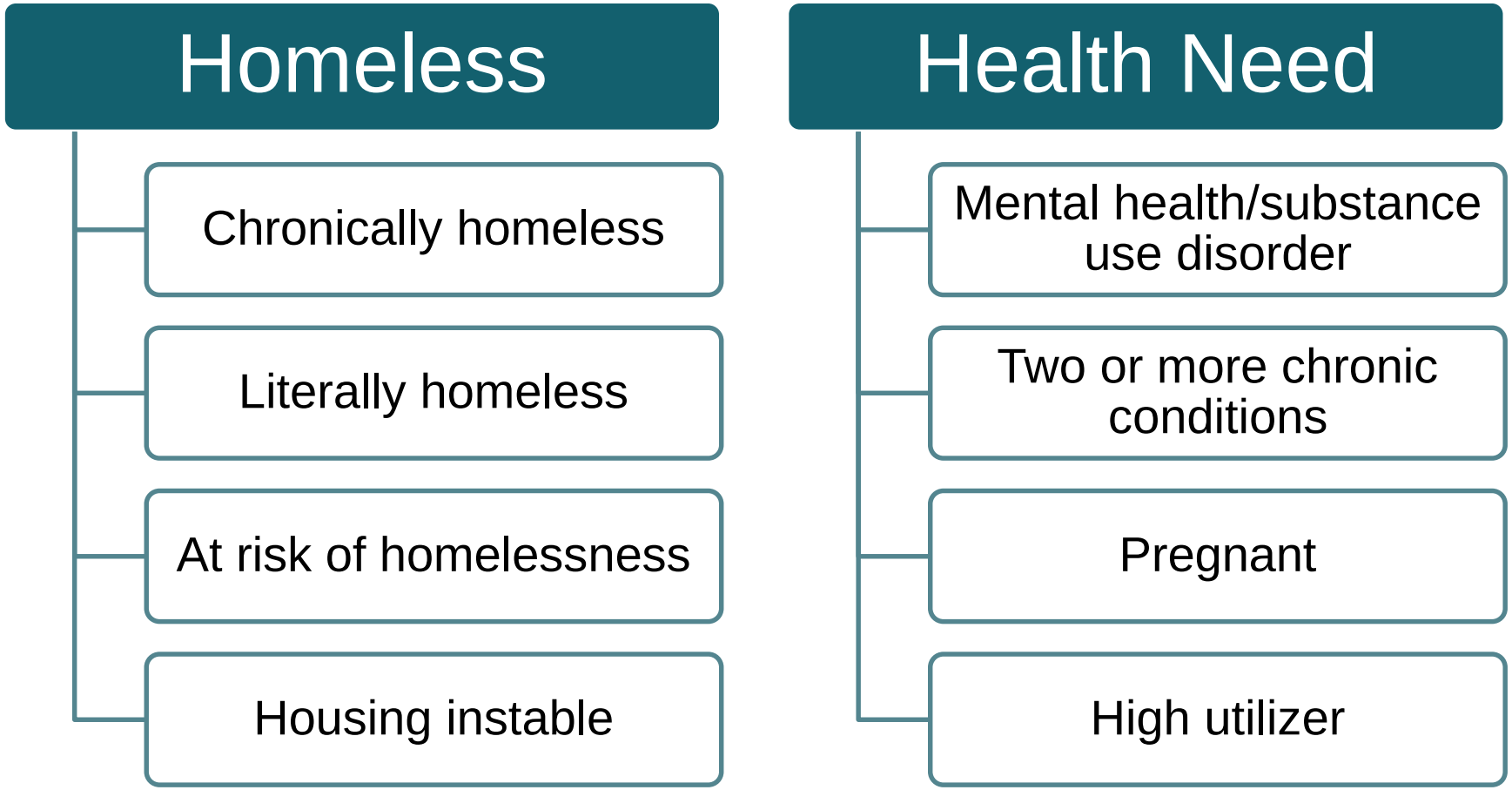
- The Center for Medicare & Medicaid Services (CMS) acknowledged that it is difficult to improve health without a stable place to live.
- In 2015, CMS released guidance to states for providing housing-related activities to Medicaid members.
- Several states have since pursued changes to their Medicaid programs to address housing as a determinant of health.

Medicaid Coverage of Housing-Related Services

Medicaid Authorities

- Managed Care contracts
- 1115 Demonstration Waiver
- 1915(c) Waiver
- 1915(i) Home and Community-Based Services
- Health homes
- 1905(a) Targeted Case Management

Target Population



Housing Case Management

Pre-tenancy supports

- Performing tenant screening and housing assessment
- Developing housing support plan
- Assisting with housing application, search, and moving process
- Identifying resources to cover expenses
- Ensuring living environment is safe
- Developing housing support crisis plan

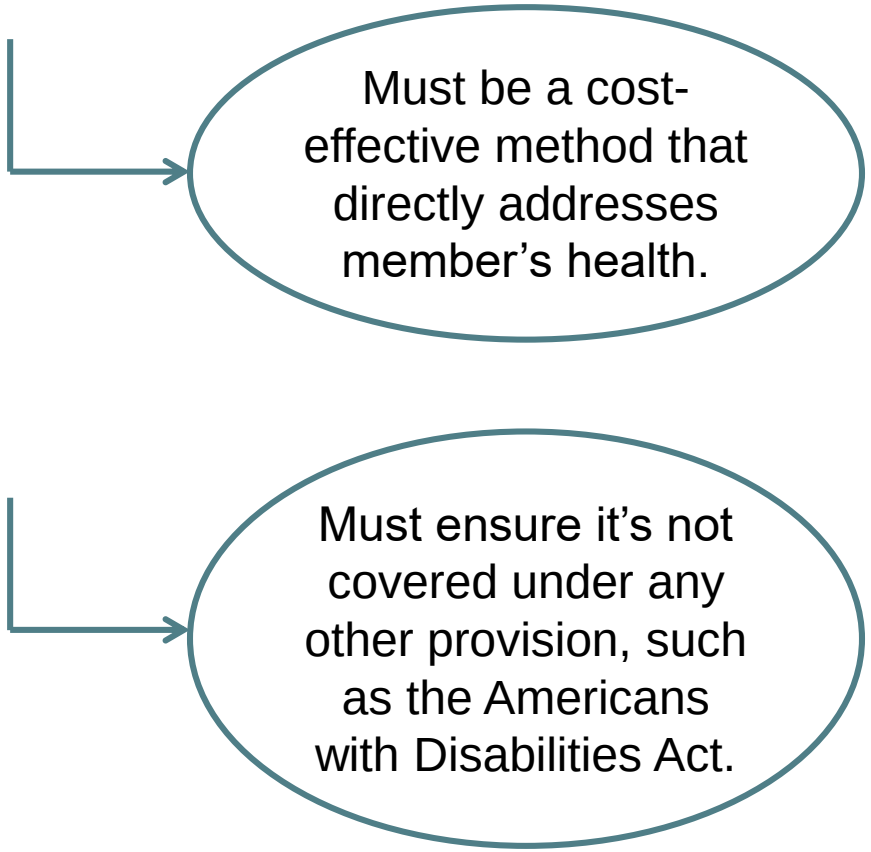
Housing Case Management

Tenancy sustaining services

- Coordinating and linking member to health services, education and employment training, probation and parole, other support groups
- Providing entitlement assistance
- Assisting with accessing supports to remain independent
- Offering landlord relationship management and tenant training

Housing Quality and Safety Improvement Services

- Repairs or remediation for issues:
  - Mold removal
  - Extermination
  - Lead paint removal
- Modifications to improve accessibility and safety of housing:
  - Ramps
  - Rails
  - Grip bars in bathtubs



Short-Term Post-Hospitalization Housing

- Not to exceed six months
- Provided due to an individual's imminent homelessness
- May not be in a congregate setting
- Similar to transitional respite care programs

Other Approved Benefits

- Care management
- Personal care services
- Meal delivery services
- Child-parent support programs
- Supportive employment services

Social Needs Screening

Necessity of Screening

- Step one to addressing social needs is asking members and patients about them.
- Screening for housing instability includes:
  - Homelessness.
  - Unsafe housing conditions.
  - Inability to pay mortgage or rent.
  - Frequent housing disruptions.
  - Eviction.

Guidelines and Tools

Screening guidelines:

- Make it short and simple
- Choose validated questions and tools
- Integrate into the clinical workforce
- Ask patients to prioritize
- Pilot before scaling

Available tools:

- Accountable Health Communities Health-Related Social Needs
- Health Begins Upstream Risk Screening Tool
- Protocol for Responding to and Assessing Patient's Assets, Risk, and Experiences (PRAPARE)

Screening Tool Example:
Accountable Health Communities

Box 1 | Accountable Health Communities
Core Health-Related Social Needs Screening Questions

Underlined answer options indicate positive responses to the associated health-related social need.

Housing Instability

1. What is your housing situation today?
   - ☐ I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building bus or train station, or in a park)
   - ☐ I have housing today, but I am worried about losing housing in the future
   - ☐ I have housing
2. Think about the place you live. Do you have problems with any of the following? Check all that apply.
   - ☐ Bug infestation
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Inadequate heat
   - ☐ Oven or stove not working
   - ☐ No or not working smoke detectors
   - ☐ Water leaks
   - ☐ None of the above

Additional Efforts

Health Care System Documentation

ICD-10-CM: Z590.0 = Homelessness

- Diagnosis code is reserved for homelessness.
- Consistent use can increase opportunities to serve patients across systems.
- There is no common or required method for asking about housing or homelessness.
- Consider the challenges to asking.

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

ASK & CODE: DOCUMENTING HOMELESSNESS THROUGHOUT THE HEALTH CARE SYSTEM

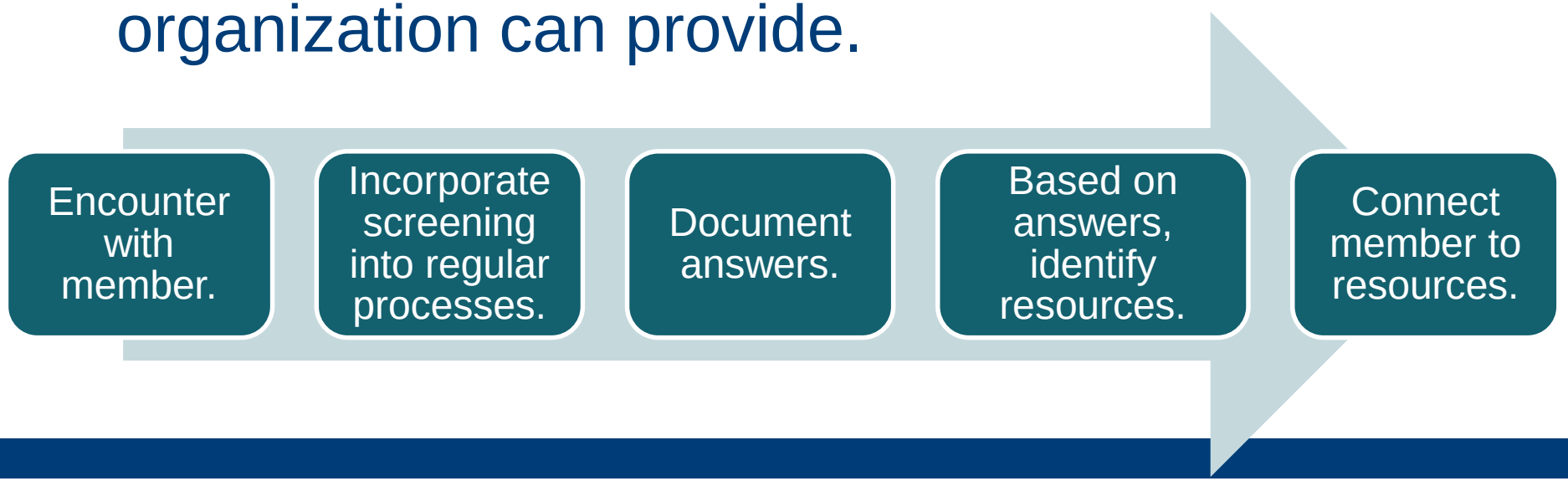
October 2016

People experiencing homelessness have disproportionately high rates of acute and chronic disease and behavioral health conditions and are high utilizers of all components of the health care system. In an era of growing focus on social determinants of health, value-based reimbursements based on risk factors, population health, and better health outcomes, more accurate data on this population is needed to inform clinical and financial decisions.

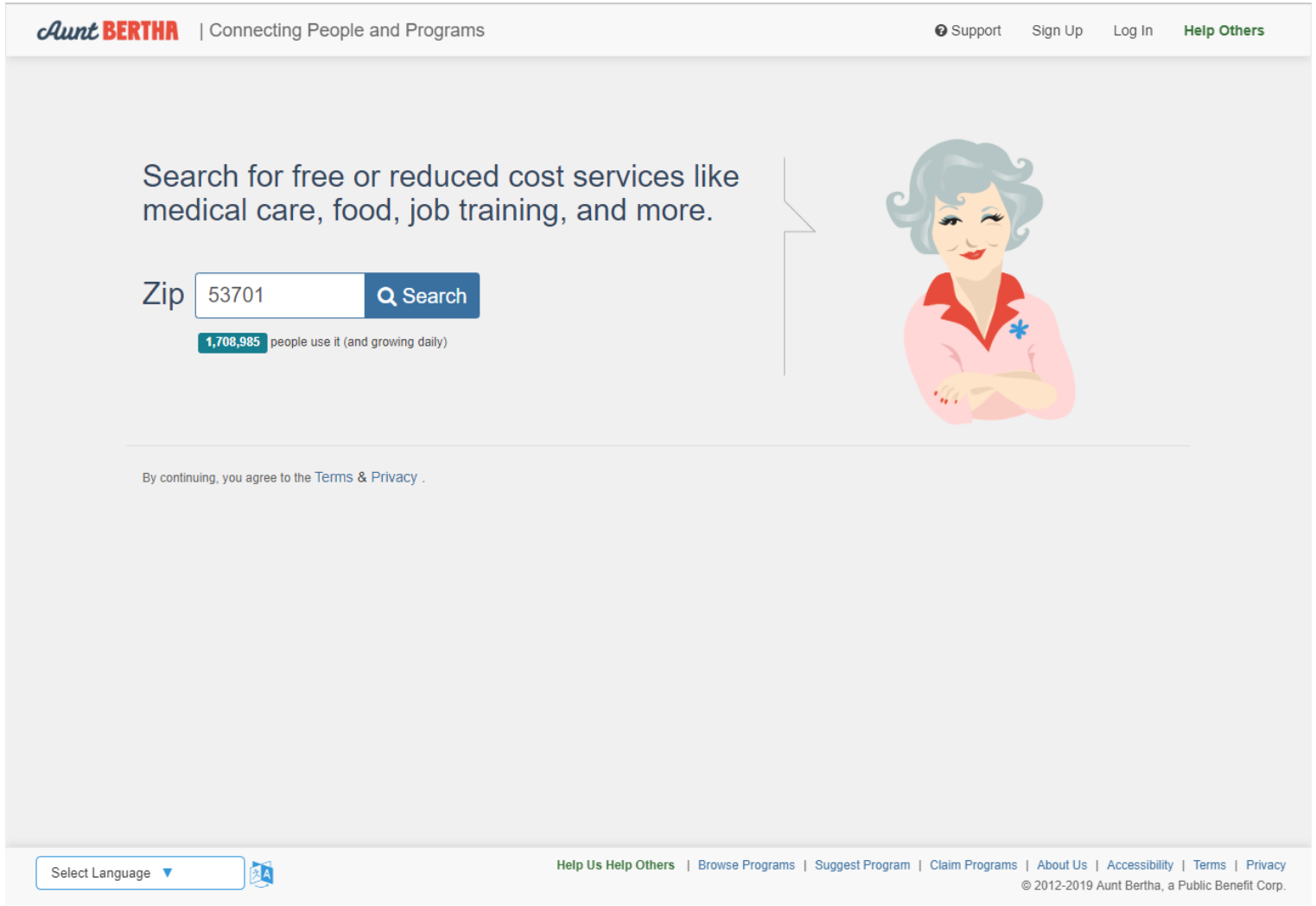
Emerging health care financing models require much more sophisticated actuarial calculations than previous payment arrangements, often taking into account risk factors such as homelessness. Homelessness also has direct implications for clinical treatment decisions and integrated care models[1] and should be noted in individual patient records. This policy brief provides a rationale for using the ICD-10-CM code for homelessness, outlines the challenges to maximizing this code, and offers strategies to consider to ensure health care providers ask about homelessness and record patients' housing status. This data is highly relevant to clinicians and administrators at health centers, hospitals, state Medicaid systems, Medicaid managed care organizations, and public health departments.

Referrals

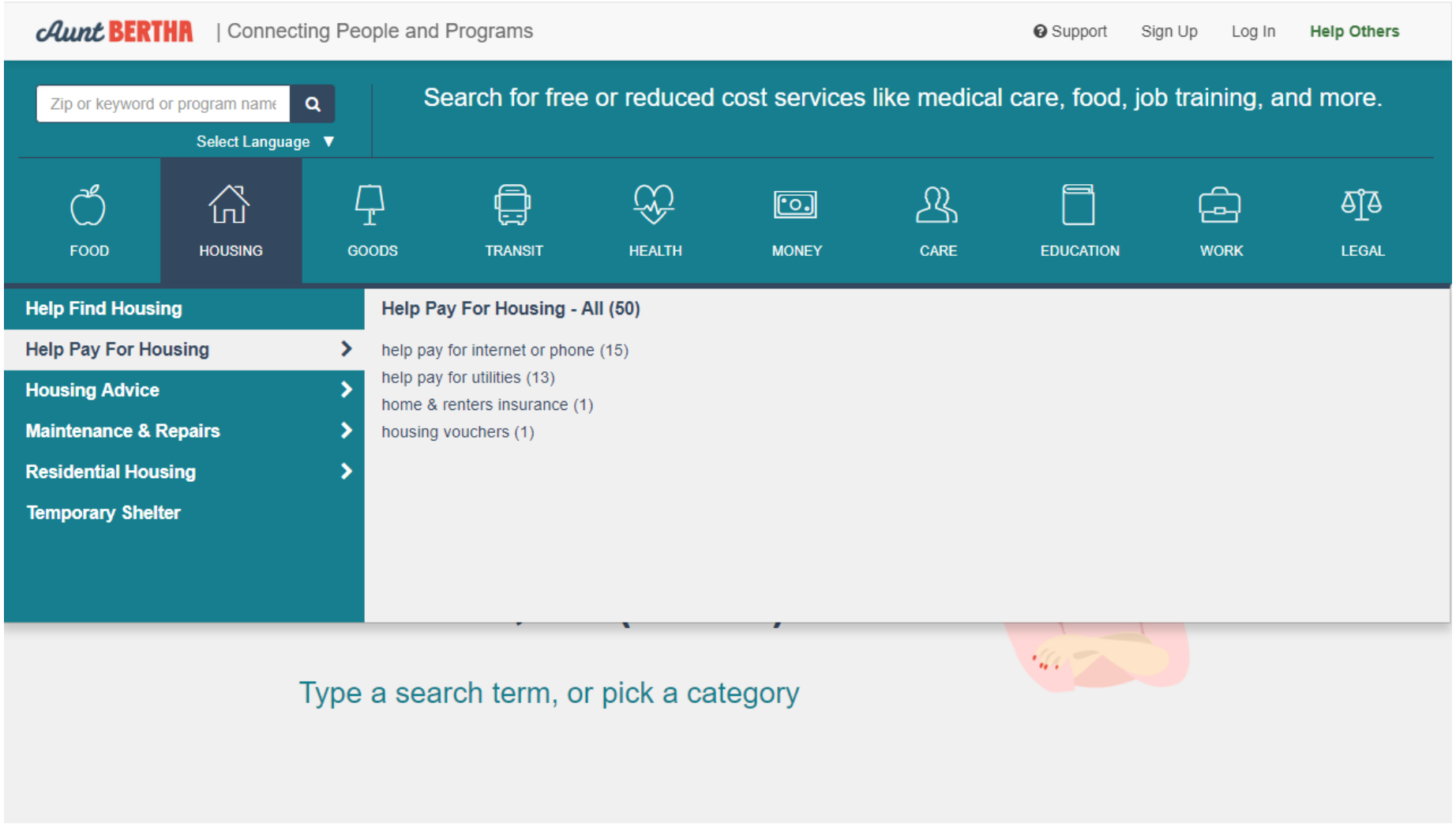
- Consider a process after a homeless member is identified.
- Use referral databases.
- Partner with local agencies and programs.
- Consider benefits or resources your organization can provide.



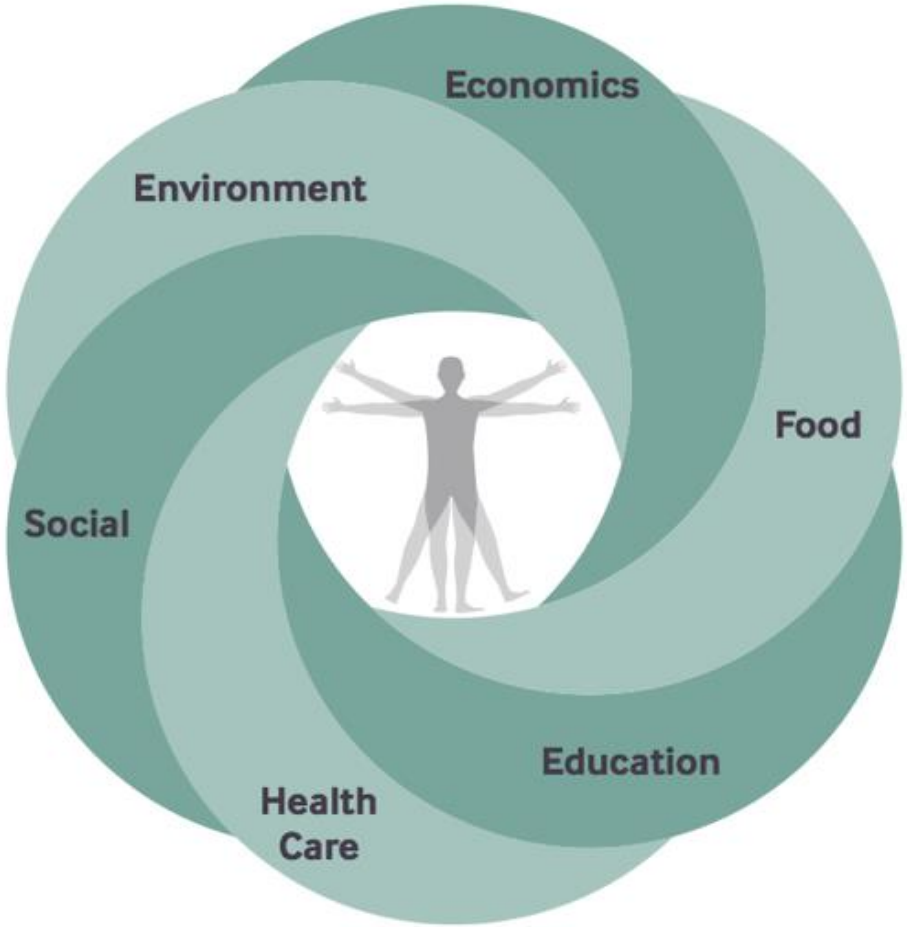
Referral Resource Example



Referral Resource Example



Breaking Silos



NEJM Catalyst (catalyst.nejm.org) © Massachusetts Medical Society

Questions?

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Presentation: IMPACT Homelessness Initiatives

Emily Kenney

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IMPACT
Changing Lives. For Good.

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A SYSTEMIC APPROACH TO ENDING HOMELESSNESS: COORDINATED ENTRY

EMILY KENNEY, LCSW

COORDINATED ENTRY PROGRAM DIRECTOR

IMPACT, INC.

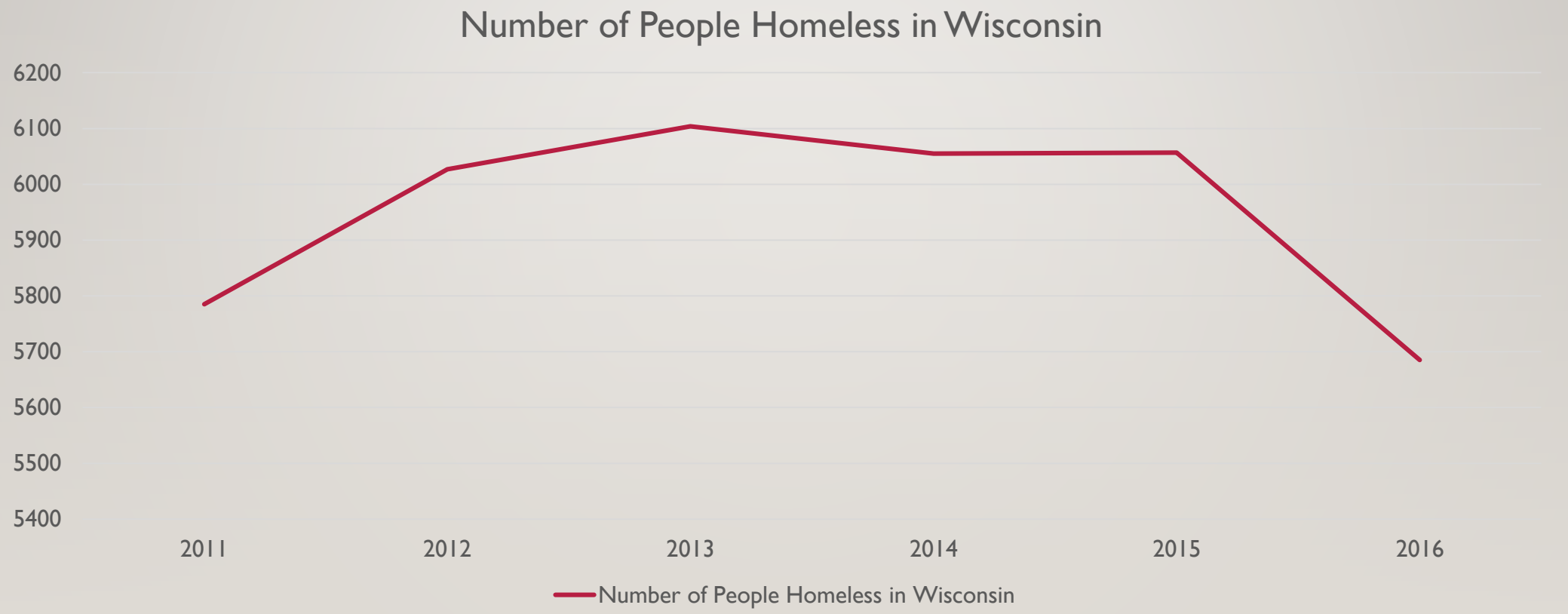
THE "HOUSING READY" MODEL

- You shouldn't put someone who is unprepared into a situation in which they may fail.
- Addressing the reason a person is homeless will ultimately create a situation in which they do not become homeless again.
- People need to show buy in and willingness to meet service providers halfway.

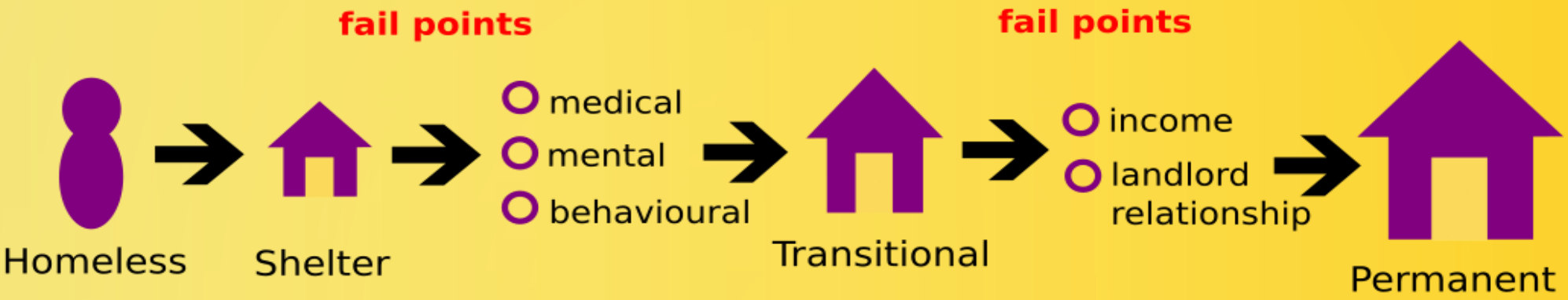
IN PRACTICE:

- Shelters with case managers, strict rules, goals largely determined by case management
- Transitional housing (up to 2 years) with case managers, strict rules
- Permanent housing?
  - Maybe Permanent Supportive Housing with case managers, strict rules, but no goals or end date
  - Maybe a community voucher (like Section 8)
  - Maybe family or friends
  - Maybe private landlords (like a rooming house)
- Street outreach groups meeting with the same people over and over

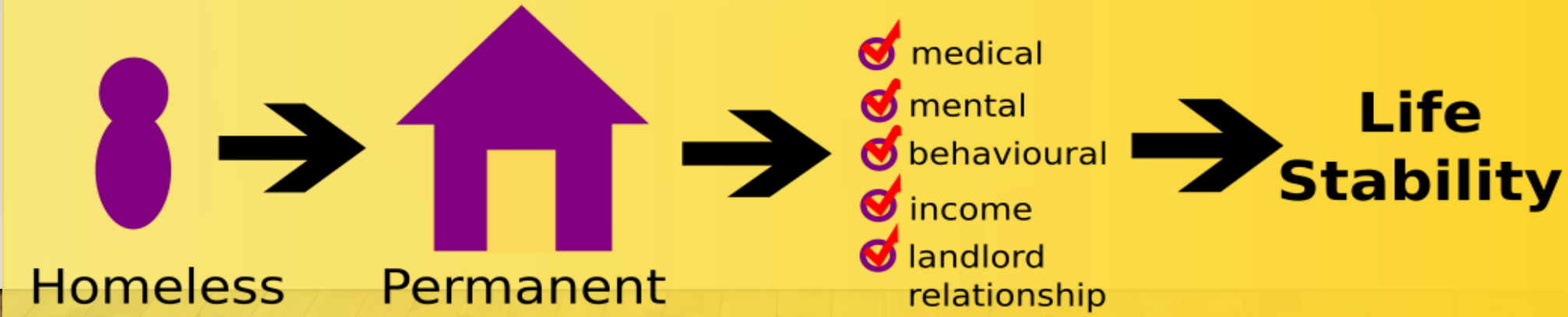
BUT WAS IT WORKING?



Housing Readiness

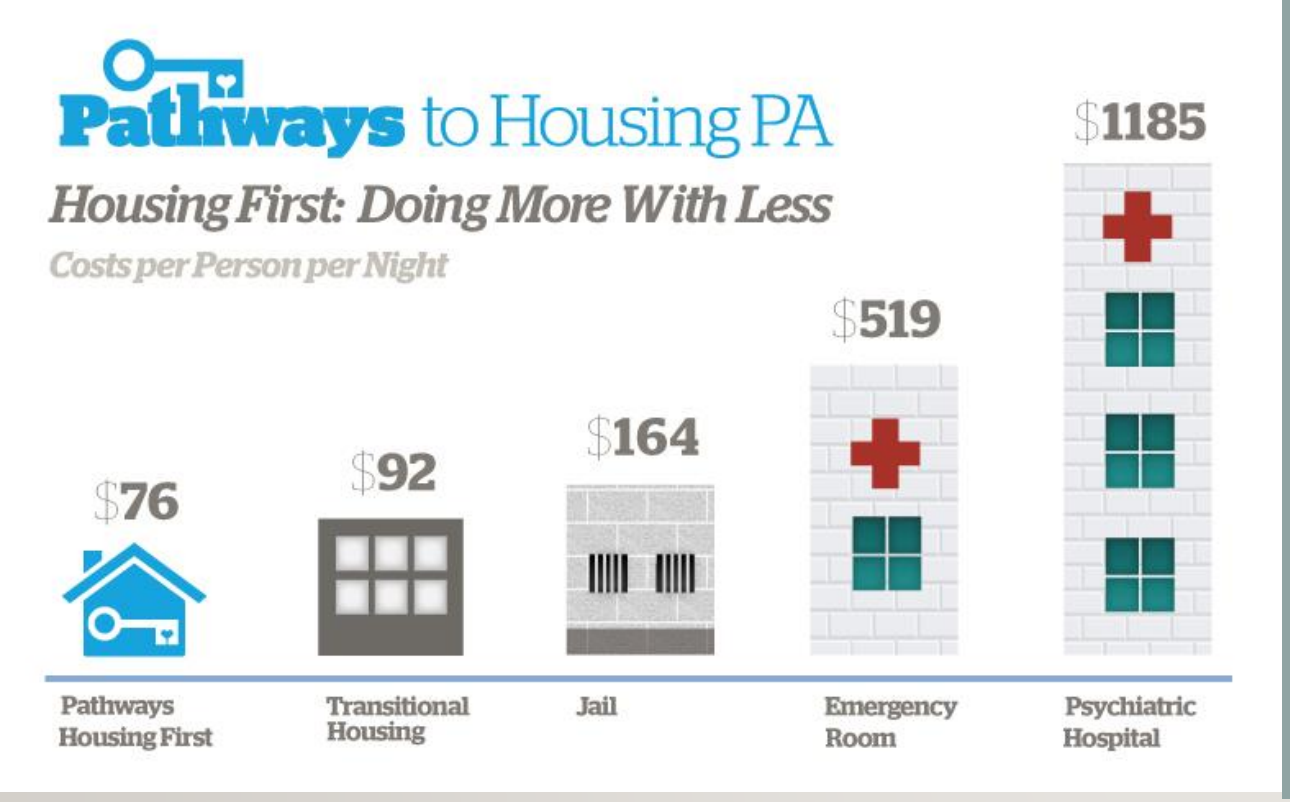


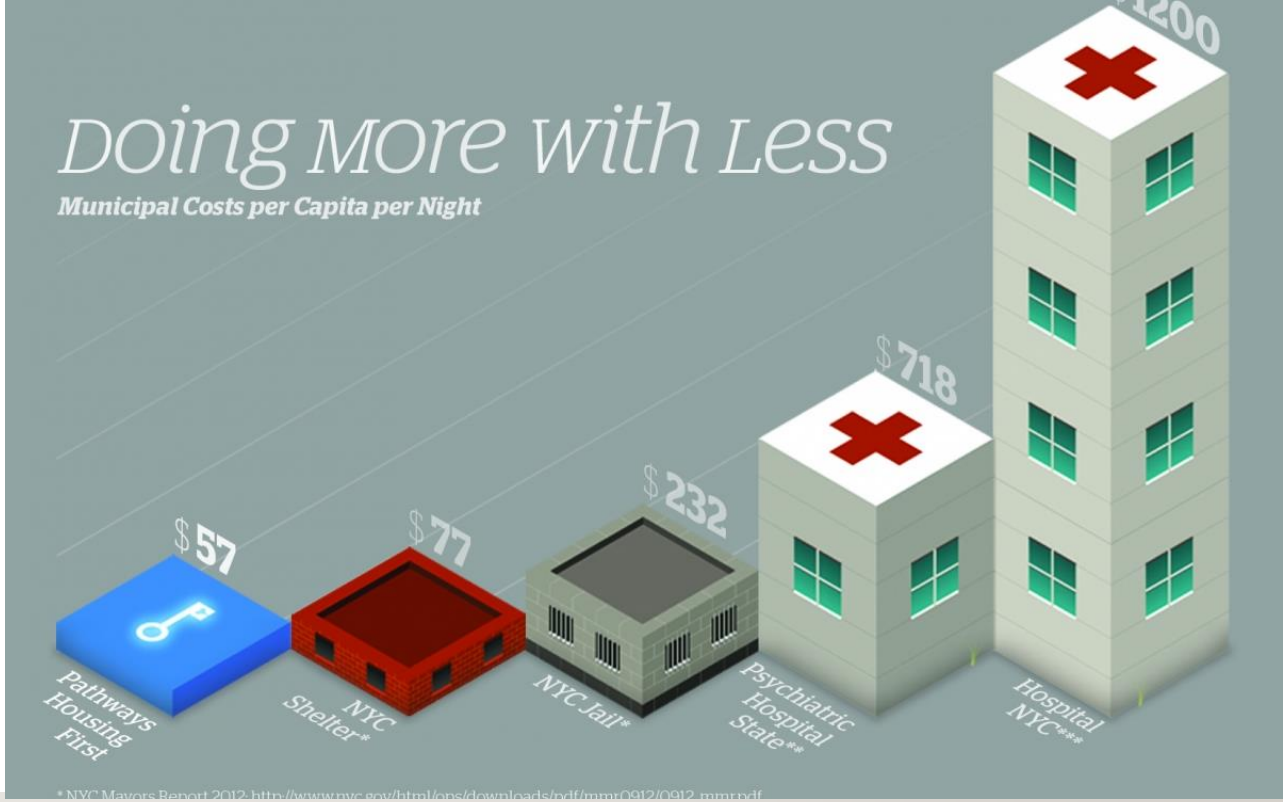
Housing First



"HOUSING FIRST" MODEL

- **Housing solves homelessness**
- Housing creates stability
- Stability allows people to work on the reasons they became homeless
- Stability allows for recovery
- Engagement is key





Pathways PA = $76 per day

Pathways NY = $57 per day

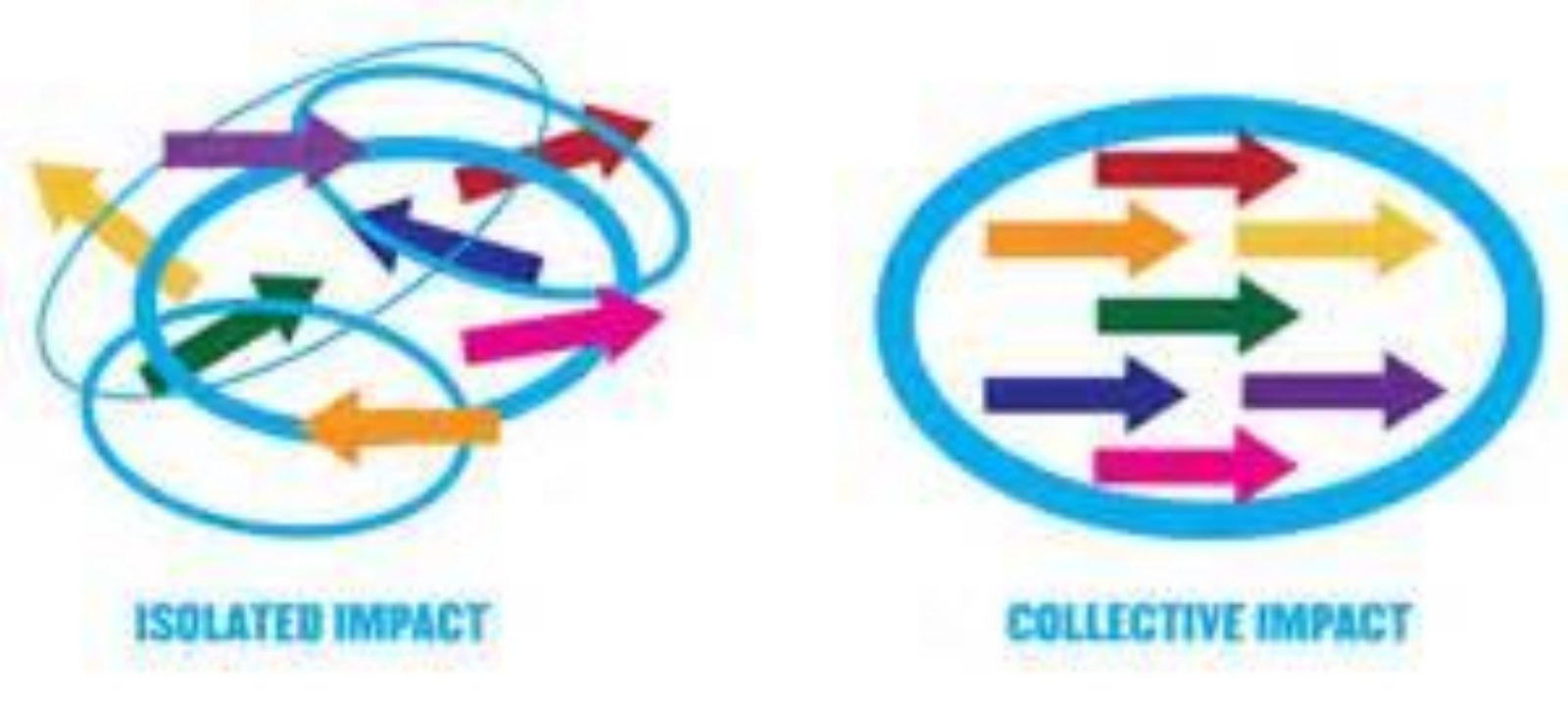
HF Milwaukee = Current numbers at less than $30 per day

This covers rent subsidy and wraparound case management services

HOUSING RETENTION RATES

- Across the Milwaukee Community, housing retention rates using the Housing First model have increased
- 85-99% of residents have not returned to homelessness for a year after first entering the program across Milwaukee
- One program that switched from the traditional transitional to permanent housing model saw a that their clients' success rates **doubled** when they started to use the Housing First model for Rapid Rehousing
  - 44% of their clients did not return to homelessness from permanent housing in the traditional transitional to permanent model
  - 88% of their clients did not return to homelessness when they went straight to permanent housing with a no barrier approach to program entry

COLLECTIVE IMPACT



SO…WHAT IS COORDINATED ENTRY?

- It incorporates 3 parts:
  - Assessment of clients to evaluate their strengths and needs
  - Placement and Referral of clients based on their strengths, needs, and vulnerability
  - Informing and implementing system change from a first-come, first-served model to a system-wide, housing-first, prioritized approach

HOW DOES IT WORK?

- Person connects to IMPACT 2-1-1/CE Team
- Complete a vulnerability assessment
  - Added to a spreadsheet to be able to search by vulnerability score
- Shelters and Housing Programs give availability daily
- Match clients based on their vulnerability score and eligibility criteria
- Data logged, tracked, and reported

HOW DO I LEARN MORE?

Contact Emily for more information:

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Panel Discussion

Leah Ramirez

Homelessness Services Policy Manager, DHS

Emily Kenney

Coordinated Entry Program Director, IMPACT, Inc.

Bob Burmeister

Founder, Mr. Bob Under the Bridge

Pam Alarcon

Community Connect Consultant, *i*Care

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Questions for the Panel

Forum Discussion

Award Presentation

*i*Care Provider Service Excellence Award

- Recognizes *i*Care providers who have recently offered our members superior service that exemplifies *i*Care's mission.
- Providers can be nominated by *i*Care Employees or others.
- Nominations are reviewed by a Provider Rewards Program committee.
- Winning providers receive:
  - an award to display in their place of business
  - positive publicity
  - $500 bonus

*i*Care Provider Service Excellence Award

Congratulations to the winner of the *i*Care Provider Service Excellence Award!

Forum Materials Online

- Forum materials including the presentation, registrant list and video will be available on iCare's website at the following link:
  - https://www.icarehealthplan.org/BoardCommittees/SPAC/

- An event evaluation survey will be sent to all attendees via email to help gather feedback on what you thought of iCare's forum and how we might improve future forums

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