New Frontiers in Coordinating Housing and Medicaid Services for People with Behavioral Health Conditions

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Washington, DC
April 21, 2016
Welcome

Moderator

Jonathan Brown
Mathematica Policy Research
The Center for Studying Disability Policy (CSDP) was established by Mathematica in 2007 to provide the nation’s leaders with the data they need to shape disability policy and programs to fully meet the needs of all Americans with disabilities.
Today’s Speakers

Jonathan Brown
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The Housing Challenge: Key Strategies Used by the Money Follows the Person (MFP) Grantees

Center for Studying Disability Policy
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April 21, 2016
Carol V. Irvin
MFP Rebalancing Demonstration: Principal Aims

● Reduce reliance on institutional care
● Develop opportunities for community-based long-term care
● Enable people with disabilities to participate fully in their communities and improve their quality of life
Basics of How States Achieve these Aims

1. Transition people

2. Provide LTSS, including housing supports

3. Earn enhanced federal funds

4. Use funds to increase access to community-based services, including housing supports

LTSS = long-term services and supports
45 Grantees Transitioned Nearly 52,000
by the End of 2014

Note: New Mexico and Florida received MFP grant awards in 2011. New Mexico withdrew from the program in 2012, Florida withdrew in 2013, and Oregon withdrew in 2014.
States Are Transitioning People with All Types of Disabilities

Distribution of MFP participants by population subgroups, 2014

- Older adults 37%
- People with physical disabilities 37%
- People with intellectual disabilities 15%
- People with mental illness 9%
- Other 3%

Source: Mathematica analysis of state MFP grantees’ semiannual progress reports, July to December 2014. N = 45
Housing Choice Differs by Population

Types of community housing by targeted population, 2014

- **Older adults**:
  - Home: 45%
  - Apartment: 35%
  - Assisted living: 14%
  - Small-group home: 6%

- **Younger adults with physical disabilities**
  - Home: 41%
  - Apartment: 46%
  - Assisted living: 6%
  - Small-group home: 7%

- **People with intellectual disabilities**
  - Home: 9%
  - Apartment: 12%
  - Assisted living: 1%
  - Small-group home: 78%

- **People with mental illness**
  - Home: 35%
  - Apartment: 57%
  - Assisted living: 2%
  - Small-group home: 6%

Source: Mathematica analysis of state MFP grantees’ semiannual progress reports for 2014.
Greatest Challenges to MFP Transition Programs

Housing
Lack of affordable and accessible housing

Services
Insufficient capacity to serve some people in community settings
The Housing Challenge

- Medicaid beneficiaries in institutional care have few financial resources
- Housing-related subsidies are insufficient to meet the need

Project Access in 2001
- 400 vouchers
- 11 public housing authorities (PHAs)

Non-Elderly Disabled Category Two (NED2) in 2011
- 948 vouchers
- 28 PHAs

Section 811 Project Rental Assistance Program
- Integrated supportive housing units for people with significant disabilities ($98 million in FY 2012 and $150 million in FY 2013)
- 30 participating states
The Service Challenge

- A notable share of MFP participants (60% to 65%) have been treated for a behavioral or mental health condition
- Serving participants who need behavioral and mental health services requires specialized skills
- Getting those skills has been a challenge
  - The direct service workforce requires specialized skills
  - Ohio: recruiting behavioral health providers to be transition coordinators
How MFP Grantees Are Addressing the Housing Challenge
Promoting Long-Term Collaboration Between Health and Housing (1)

21 grantees report MFP developed stronger interagency collaboration
Promoting Long-Term Collaboration Between Health and Housing (2)

- 2011 NED2 housing choice: 97% of vouchers went to MFP states
  - MFP and local PHAs partnered in nearly every state
  - Produced new Medicaid-PHA partnerships at state and local levels
  - Supported transitions that would not have occurred otherwise (Hoffman et al. 2014; Lipson et al. 2014)

- The 2012 Real Choice Systems Change grants
  - Six MFP programs participated
  - Develop and strengthen Medicaid-PHA partnerships

- MFP and local PHAs work together to give MFP participants priority status on waiting lists
  - Mississippi
Increasing the Supply of Housing Options and Resources

- Advocating for more investment
- Promoting supportive housing
- Addressing shortage of small-group homes
- Financing modifications to existing units
Using More Housing Resources

Information resources to educate stakeholders

Rental and bridge subsidies

Housing specialists
- State-level coordination and policy development
- One-on-one help to locate housing for participants
Providing Tenant Assistance and Support

- **Personal barriers**
  - Missing documents
  - Bad debt

- **Financial assistance**
  - One-time moving expenses
  - Pre-transition visit
  - Adaptive aids
  - Pantry setup
  - Basic linens

- **Environmental safety**
  - Pest eradication
  - Accessibility features

- **Independent living skills**
  - Medication management
  - How to be a good tenant
  - Peer supports

- **Stabilization services**
Key Results
Effects on Transition Rates from Institutional to Community-Based Care

- MFP associated with an increase in transition rates among younger adults with physical disabilities
  - Roughly 4 percentage points higher after MFP began
    - Base transition rate was about 10% before states began implementing MFP programs
  - Estimates suggest that by 2010, 95% of MFP participants in this target population would not have made the transition without MFP
Large Improvements in Quality of Life

Source: Mathematica’s analysis of MFP quality-of-life surveys and program participation data submitted to CMS through March 2015. N = 5,571
Sustaining the Momentum (1)

- CMS informational bulletin—June 2015
  - When Medicaid can reimburse for housing services
    - Individual-level housing transition services
    - Individual-level housing and tenancy-sustaining services
    - State-level housing-related collaborative activities
Sustaining the Momentum (2)

- The Medicaid Innovation Accelerator Program
  - Technical assistance program for state Medicaid programs
  - Four topic areas
    - Substance abuse disorders
    - Beneficiaries with complex needs
    - Physical and mental health integration
    - Community integration—LTSS
      - Housing supports—one of two areas of support
      - Housing tracks—(1) housing tenancy and (2) state Medicaid-housing agency partnerships
For More Information

● CMS
  – Effie George
    ▪ Effie.George@cms.hhs.gov
  – Martha Egan (housing supports)
    ▪ Martha.Egan@cms.hhs.gov
  – CMS MFP website

● Mathematica
  – Carol Irvin
    ▪ CIrvin@mathematica-mpr.com
  – Mathematica MFP website
References

- National evaluation annual reports for 2012 and 2014

- Overview of state grantee progress, January to December 2014

- Report from the field on leading programs

- NED2 voucher study
  - [https://aspe.hhs.gov/sites/default/files/pdf/76986/Cat2Housing.pdf](https://aspe.hhs.gov/sites/default/files/pdf/76986/Cat2Housing.pdf)
Coordinating Housing and Medicaid Services for People with Mental Health and Substance Use Disorders: A Case Study of Two State Initiatives

Center for Studying Disability Policy
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Matthew Kehn
Roadmap to the Presentation

- Study background, rationale, and methodology
- Case studies
  - Illinois’s Care Coordination Entities
  - Massachusetts’s Community Support Program for Ending Chronic Homelessness
Study Background

● ASPE-supported contract (2013–2015)

● Rationale for the study
  – Fragmented financing and delivery of health and social services
  – Some states are taking advantage of the flexibility Medicaid offers to try new strategies for coordinating care
  – Policymakers and stakeholders need information about how these states finance, structure, and implement their efforts
  – Particular need for a better understanding of how these efforts look “on the ground”

● Study purpose: conduct case studies of states using innovative strategies to coordinate care for Medicaid beneficiaries with mental health/substance use disorders
Methodology

● State selection criteria
  – Strategy for coordinating physical, behavioral health, and supportive services
  – Coordination of service systems or funding streams in one service arrangement at the state or regional level
  – Coordination with housing

● Data collection
  – Review of publicly available information, such as reports and press releases
  – Phone interviews with officials from state Medicaid and other state health agencies, and with representatives of managed care organizations (MCOs)
  – Site visits to conduct interviews with various providers, workforce members, and consumer representatives
Illinois

Care Coordination Entities (CCEs)
Rationale and Goals

**Rationale**
- People with serious behavioral health conditions require intensive in-person care coordination, best provided by local community-based organizations.

**Time frame**
- CCEs established in late 2013/early 2014.

**Select goals**
- Increase number of beneficiaries enrolled in a care coordination program.
- Test provider capacity to implement models of care coordination beyond the traditional MCO model.
- Test MCO interest in contracting for in-person care coordination services.
- Include CCEs in health home 2703 application.
Target Population

High-cost Medicaid beneficiaries, particularly those with serious mental illness, substance use disorders

Medicaid

Six regional CCEs

Auto-enrollment (1,000–1,500 per CCE)
Example of a CCE Structure

Medicaid provides CCEs with:
- Capped number of beneficiaries
- Technical assistance
- Historical and ongoing Medicaid claims data
Financing

**State Medicaid agency**

Medicaid pays the CCE lead agency a per member, per month (PMPM) fee using federal and state funds.

**CCE lead agency**

Lead agency uses PMPM fee to cover care coordination costs.

**CCE providers**

Medicaid fee-for-service (FFS) reimbursement for everything but care coordination.
Role of Care Coordination Team

- Reach out to beneficiaries
- Conduct needs assessment
- Connect beneficiaries to CCE member services
- Follow up on treatments, prescriptions, and referrals
- Provide health education
- Teach self-management techniques

Care team
Key Ingredients for Coordination

- Reimbursement for in-person care coordination
- Capacity to assemble care team with knowledge of local resources
- Market for the type of care coordination provided by a CCE

Stakeholder perspectives
Constraints and Challenges

Low enrollment of beneficiaries

Some community-based organizations lack capacity to develop CCE

No shared electronic health record or client database among member organizations

Stakeholder perspectives
Massachusetts

Community Support Program for People Experiencing Chronic Homelessness (CSPECH)
Rationale and Goals

Rationale
- Permanent supportive housing will reduce Medicaid expenditures

Time frame
- CSPECH services available since 2006

Select goals
- Stabilize and improve the lives of a high-risk, high-cost population
- Reduce the use of high-cost health services
- Reduce homelessness
Target Population

- Must meet HUD definition for chronically homeless
  - Homeless for one year or longer or at least four episodes of homelessness over prior three years
  - Has a disability
- Member of Massachusetts Behavioral Health Partnership (MBHP)—the state’s managed behavioral health organization (MBHO)
- Between 2009 and 2014, about 1,250 served
CSPECH Structure

- MassHealth authorizes reimbursement for CSPECH

- MBHP has assembled a statewide network of organizations to provide CSPECH services

- CSPECH providers typically consist of a partnership between a behavioral health provider in an MBHP network and a housing provider
CSPECH Financing

- MassHealth classifies CSPECH as a “community support program” service (a CMS-approved reimbursable service)

- MBHP is reimbursed for CSPECH services through its capitation rate with MassHealth

- CSPECH providers bill MBHP for coordination services using a flat per unit, per day case rate

- Behavioral health services reimbursed by MBHP; physical health services reimbursed by MassHealth through FFS; housing is funded through existing HUD/state funds
Coordination of Services

- CSW services are reimbursable 90 days before beneficiary is housed
- Identify potential recipient, and find available housing unit and subsidy
- Once housed, conduct needs assessment
- Connect person to needed services
- Follow up on treatments, prescriptions, and referrals
- Teach self-management and independent living skills
- Each CSW has a caseload of ~12 clients
- CSPECH services are available as long as the beneficiary is in an MBHP-covered plan and remains housed
Key Ingredients for Coordination

- Reimbursement for in-person coordination
- Use of case rate and existing service category
- Embracement of Housing First model and low-threshold housing
- Local community-based health and housing partnerships

Stakeholder perspectives
Constraints and Challenges

Service coverage gaps (non-MBHP members and duals)

Program access limited by availability of housing and subsidies

Stakeholder perspectives

Insufficient supply of mental health services
Key Findings

- Reimbursement for care coordination services is essential
- Fostering local partnerships between Medicaid and non-Medicaid service providers is critical
- States are increasingly relying on MCOs to provide coordination services
- Despite improved coordination, affordable housing remains scarce
- Service coordination and integration efforts are challenged by a lack of data
Relevant Publications


Discussant

Jennifer Ho

U.S. Department of Housing and Urban Development
Audience Q&A

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Upcoming Events

Next CSDP Policy Forum:
Thursday, June 9, 2016

Join us for a discussion of the lessons learned about vocational rehabilitation applicants and employment.
Contact Information

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