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

Presenters
Jonathan Brown, Mathematica Policy Research
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Matthew Kehn, Mathematica Policy Research

Discussant
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Washington, DC
April 21, 2016

MATHEMATICA
CENTER FOR
STUDYING DISABILITY POLICY

Welcome

Moderator

Jonathan Brown

Mathematica Policy Research

About CSDP

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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Carol Irvin
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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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Carol V. Irvin

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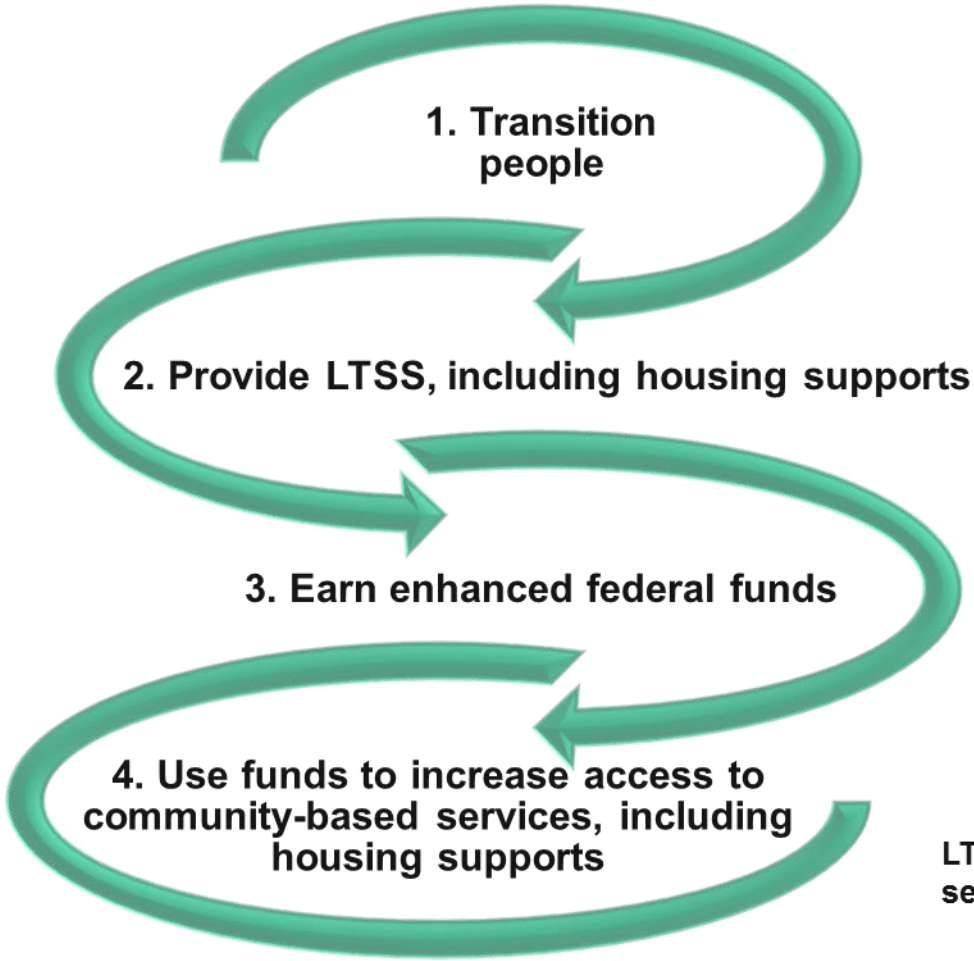
MFP Rebalancing Demonstration: Principal Aims

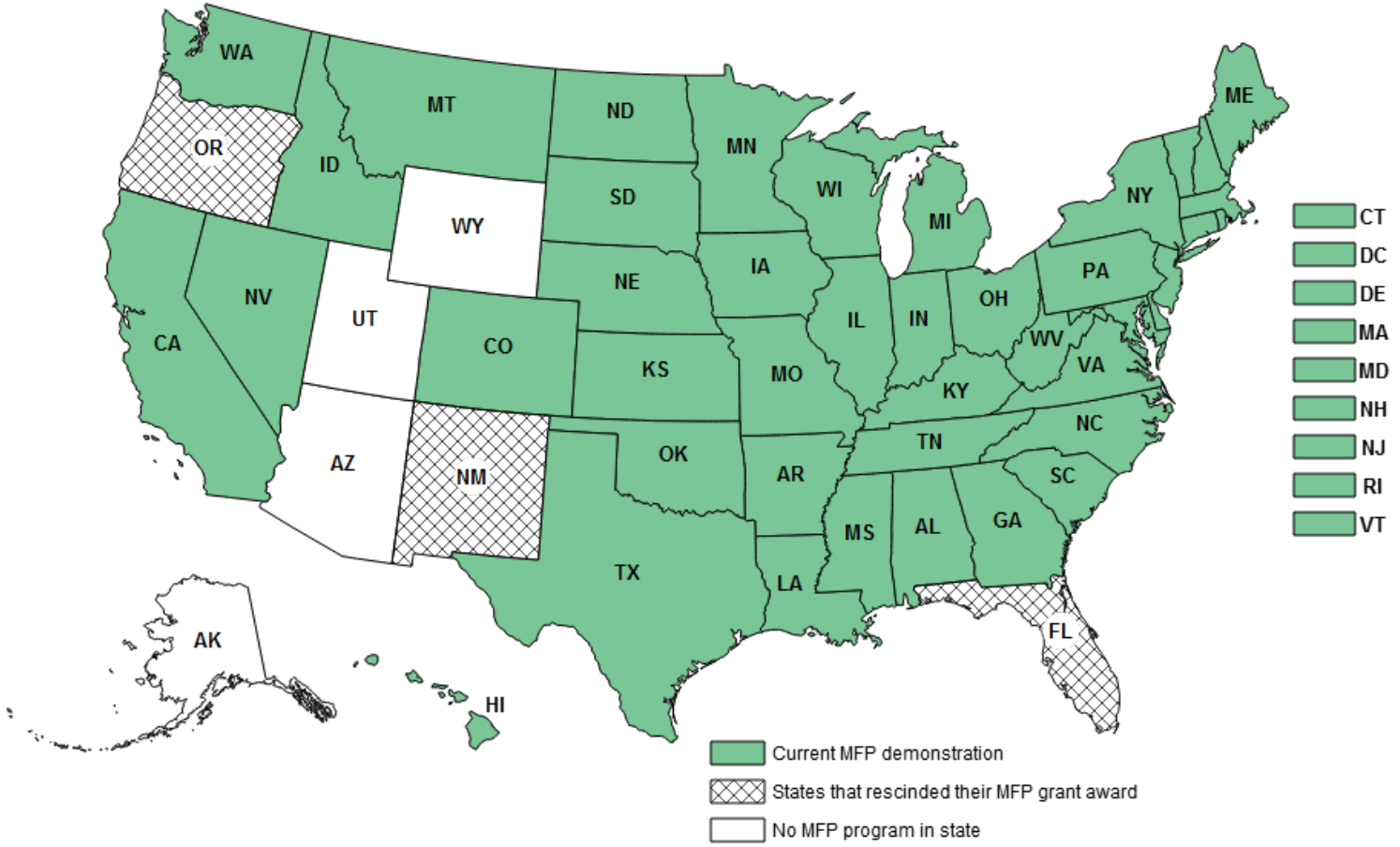
- Reduce reliance on institutional care
- Develop opportunities for community-based long-term care
- Enable people with disabilities to participate fully in their communities and improve their quality of life

Basics of How States Achieve these Aims



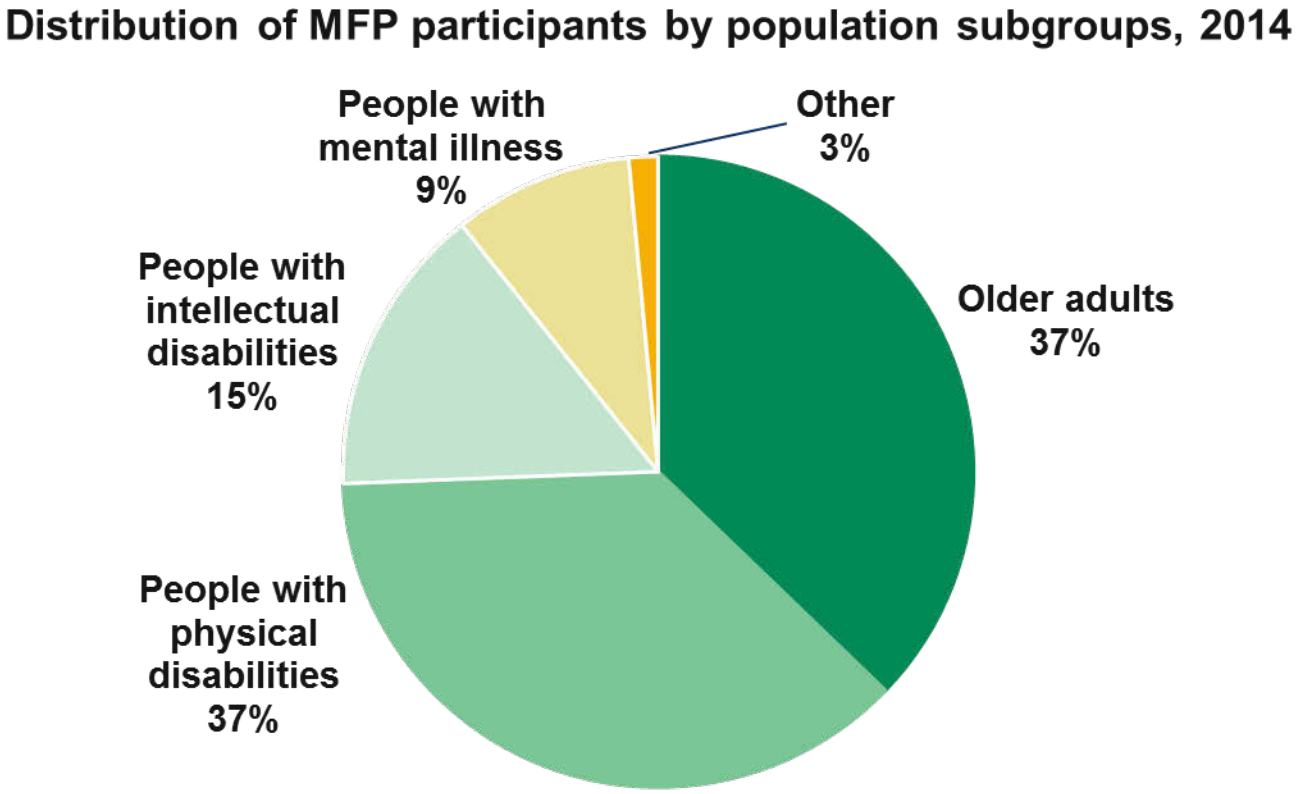
LTSS = long-term services and supports

45 Grantees Transitioned Nearly 52,000 by the End of 2014



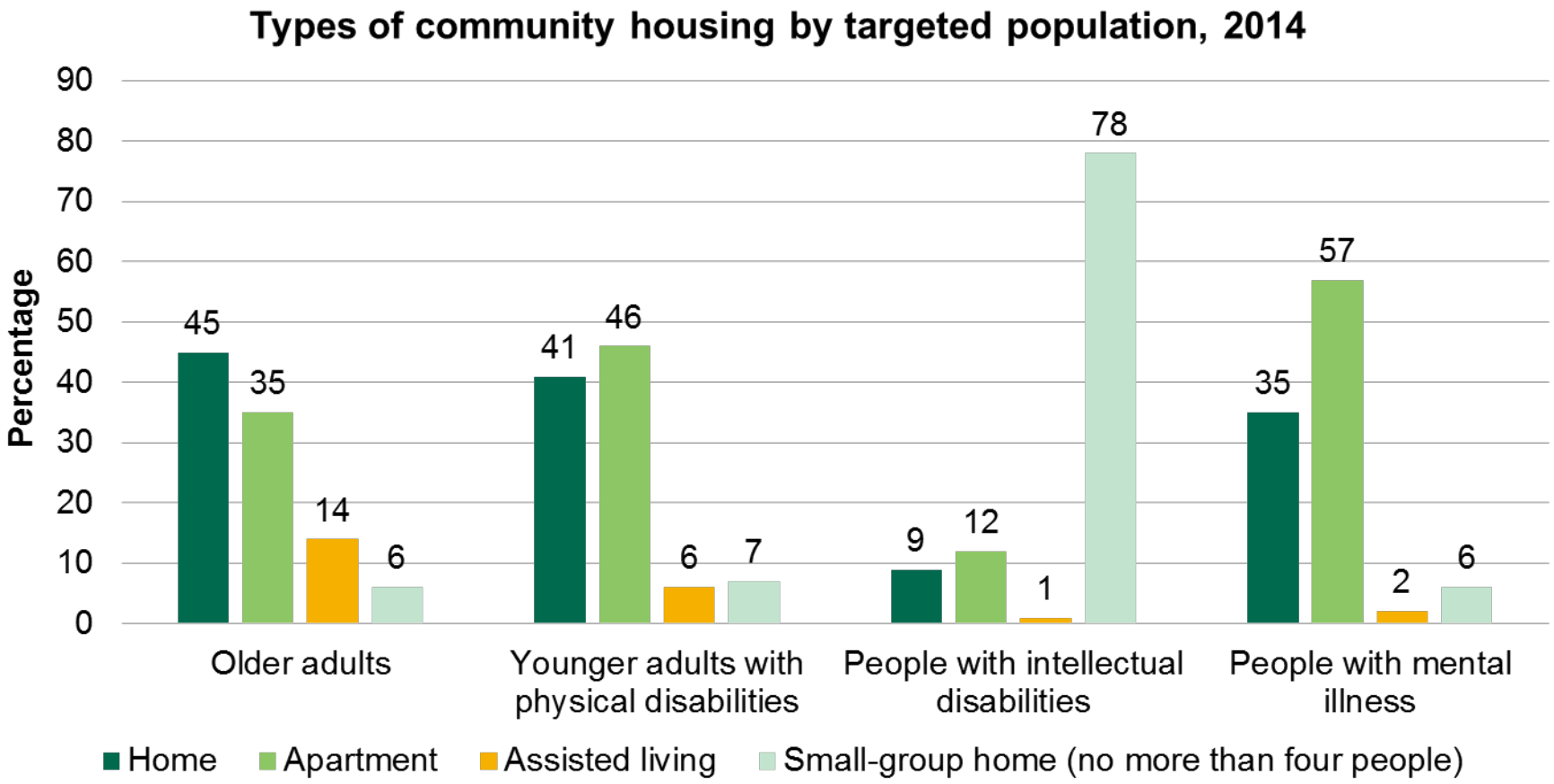
Note: New Mexico and Florida received MFP grant awards in 2011. New Mexico withdrew from the program in 2012, Florida withdrew in 2013, and Oregon withdrew in 2014.

States Are Transitioning People with All Types of Disabilities



Source: Mathematica analysis of state MFP grantees' semiannual progress reports, July to December 2014. N = 45

Housing Choice Differs by Population



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

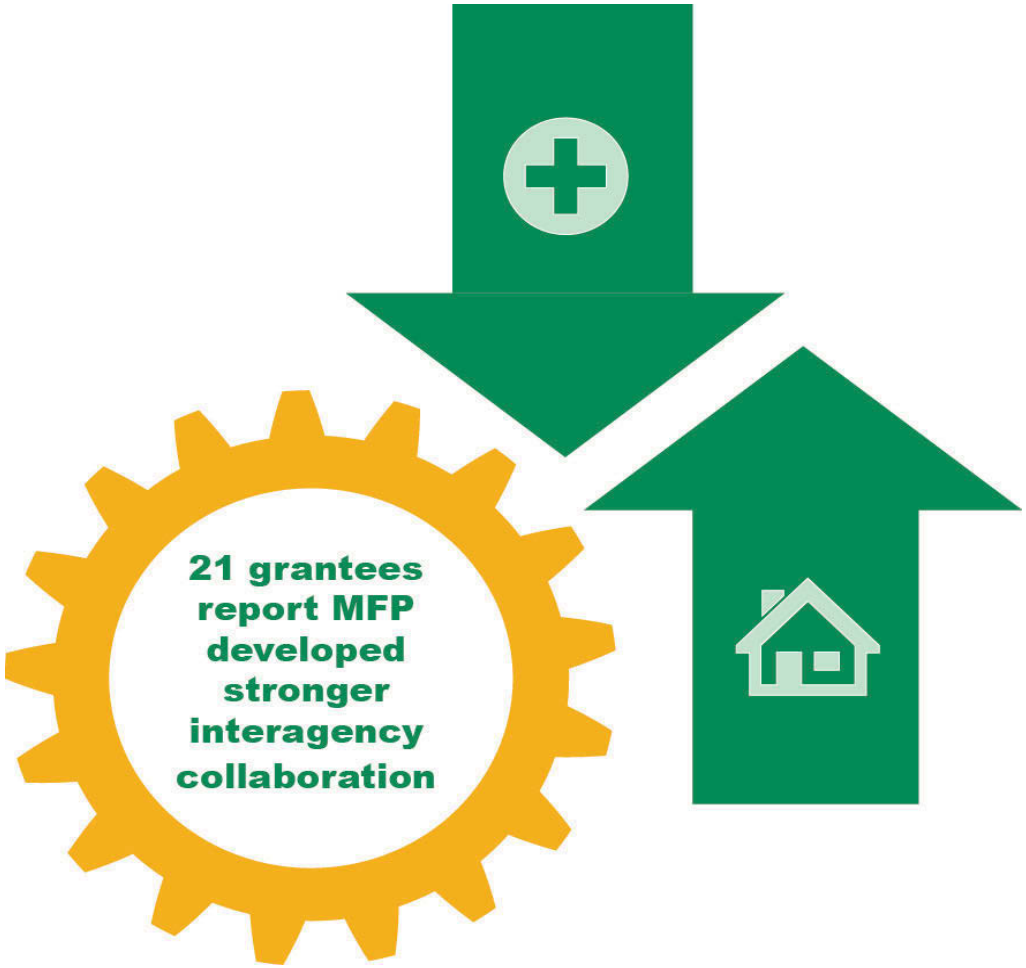
Section 811 Project Rental Assistance Program
Integrated supportive housing units for people with significant disabilities ($98 million in FY 2012 and $150 million in FY 2013)
30 participating states

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

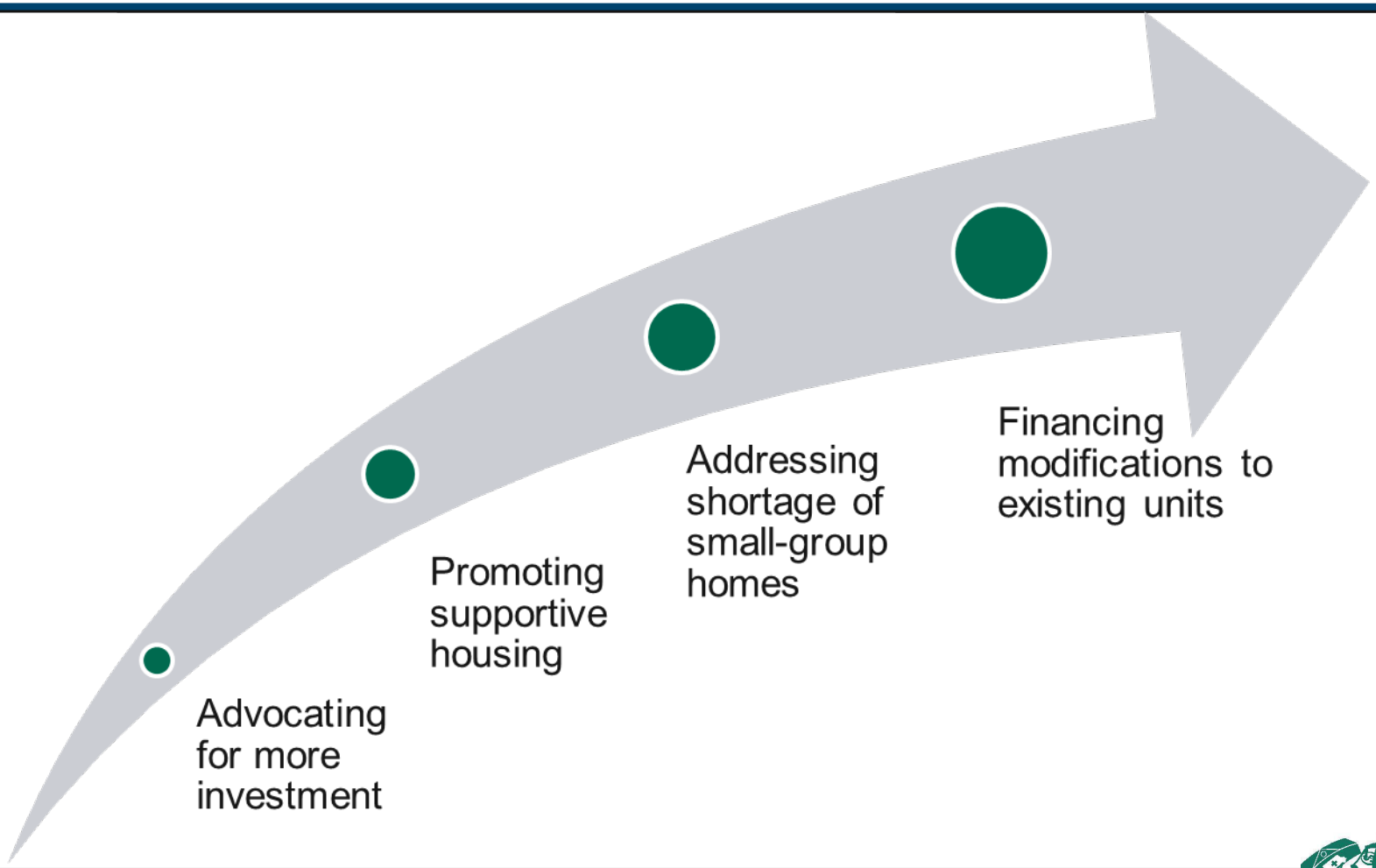
Promoting Long-Term Collaboration Between Health and Housing (1)



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



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

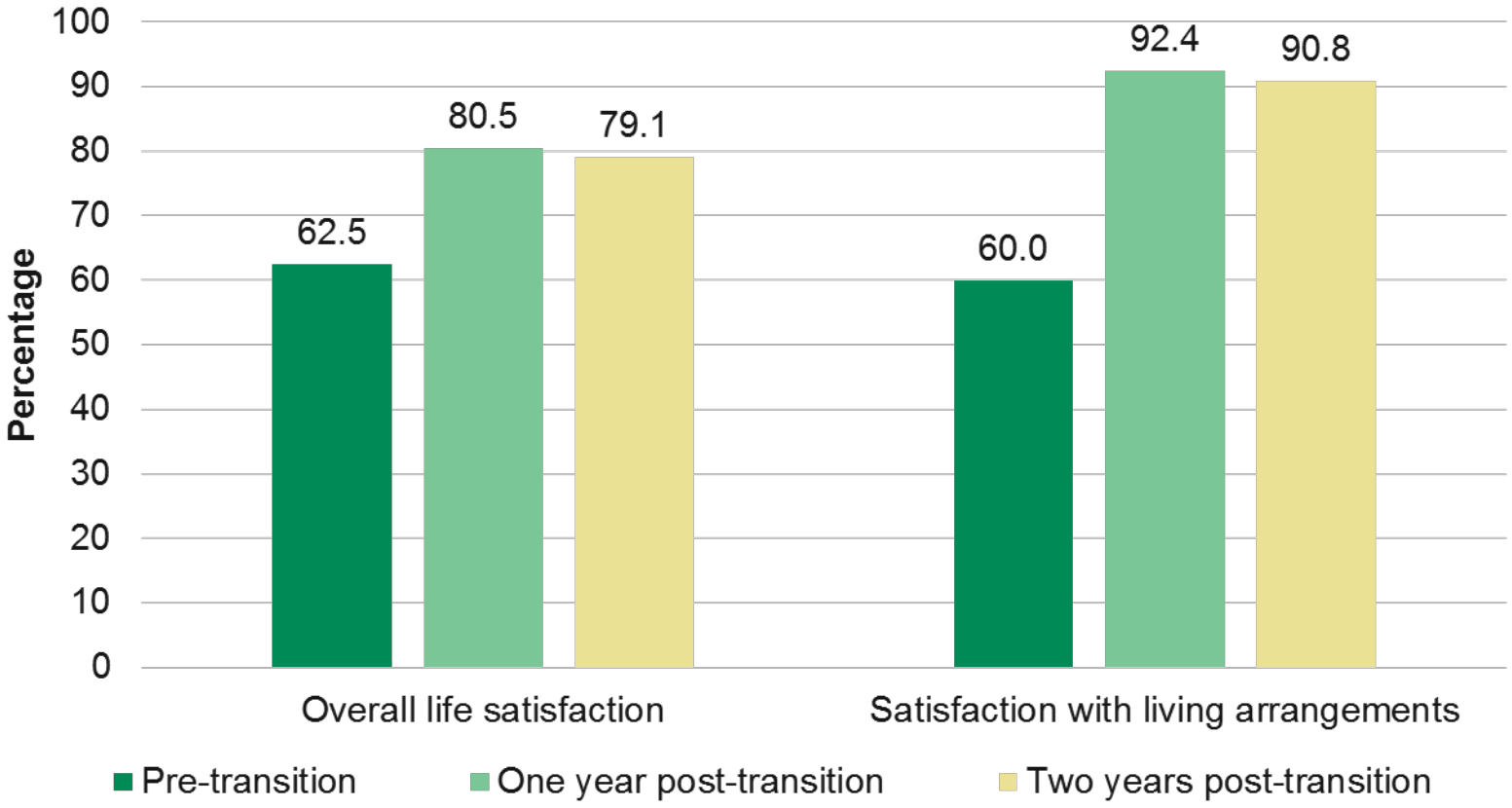
Stabilization services

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

IAP Medicaid Innovation Accelerator Program

For More Information

- CMS
  - Effie George
    - Effie.George@cms.hhs.gov
  - Martha Egan (housing supports)
    - Martha.Egan@cms.hhs.gov
  - CMS MFP website
    - https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/balancing/money-follows-the-person.html
- Mathematica
  - Carol Irvin
    - CIrvin@mathematica-mpr.com
  - Mathematica MFP website
    - http://www.disabilitypolicyresearch.org/our-publications-and-findings/projects/research-and-evaluation-of-the-money-follows-the-person-mfp-demonstration-grants

References

- National evaluation annual reports for 2012 and 2014
  - 2012 report: http://www.mathematica-mpr.com/~/media/publications/pdfs/health/mfp_2012_annual.pdf
  - 2014 report: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/balancing/downloads/mfp-annual-report-2014.pdf
- Overview of state grantee progress, January to December 2014
  - https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/balancing/downloads/mfpgranteeprogdec2014.pdf
- Report from the field on leading programs
  - https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/balancing/downloads/mfp-field-reports-16.pdf
- NED2 voucher study
  - 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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April 21, 2016

Matthew Kehn

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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

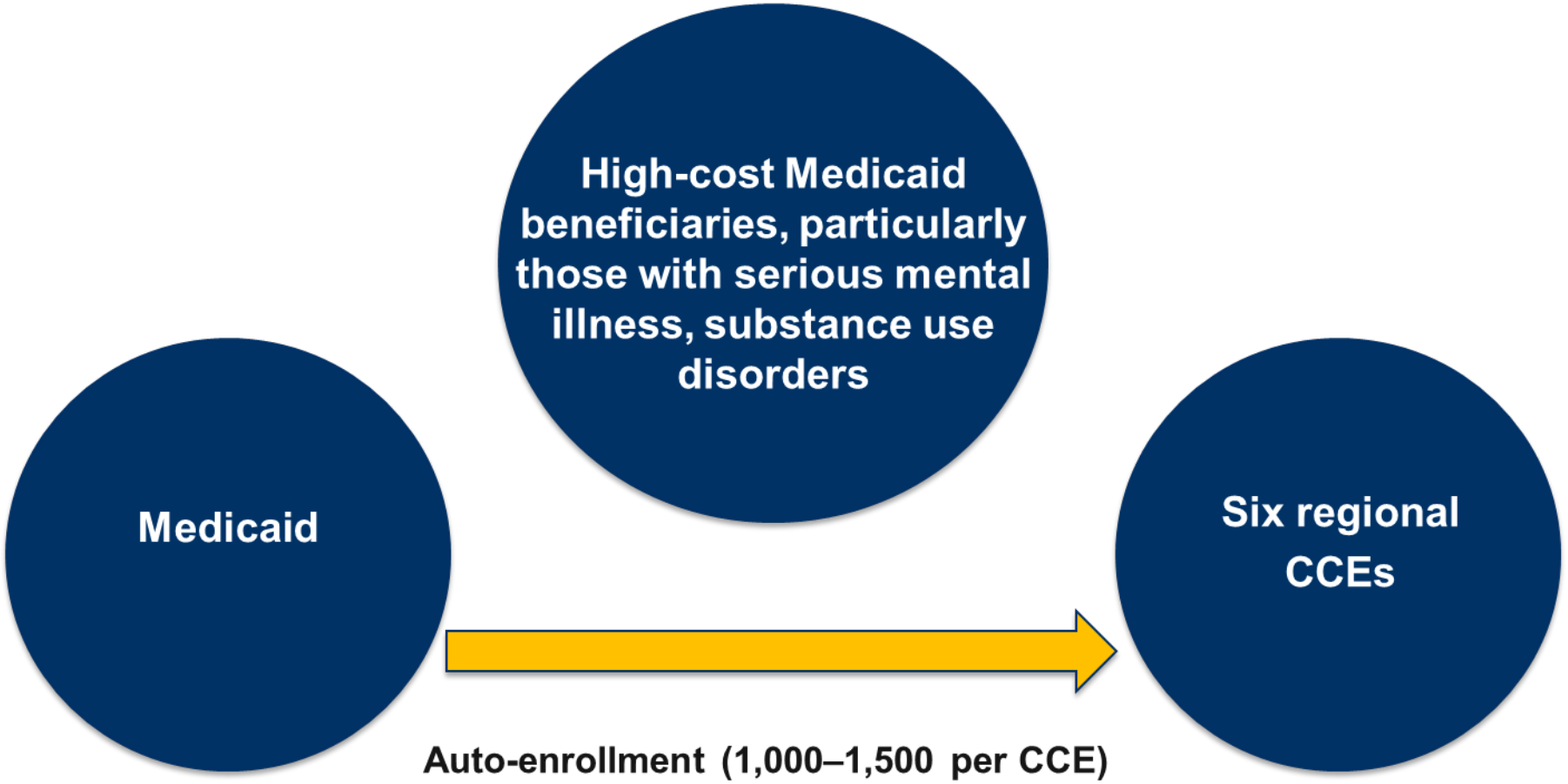
- State selection criteria
  - Strategy for coordinating physical, behavioral health, and supportive services
  - Coordination of service systems or funding streams in one service arrangement at the state or regional level
  - Coordination with housing
- Data collection
  - Review of publicly available 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

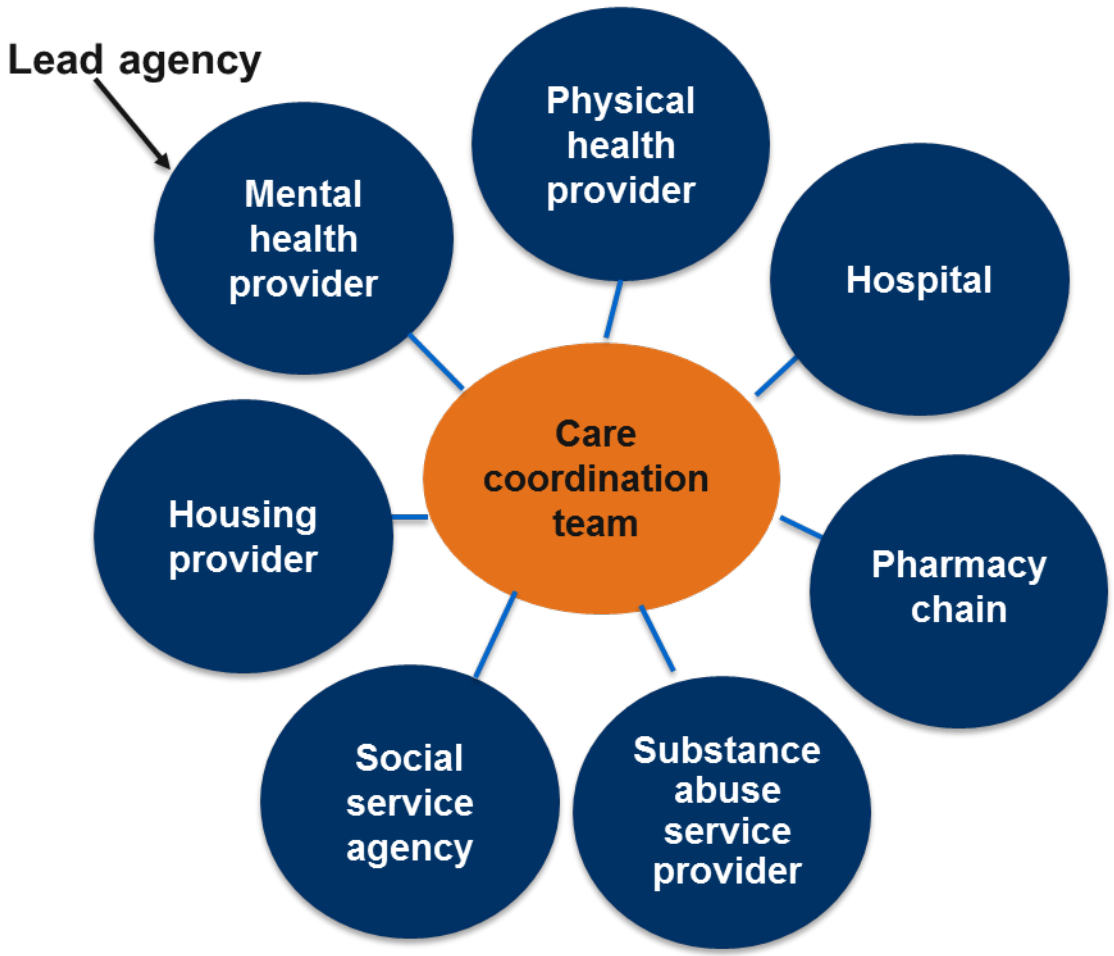
Rationale and Goals

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



Example of a CCE Structure



Medicaid

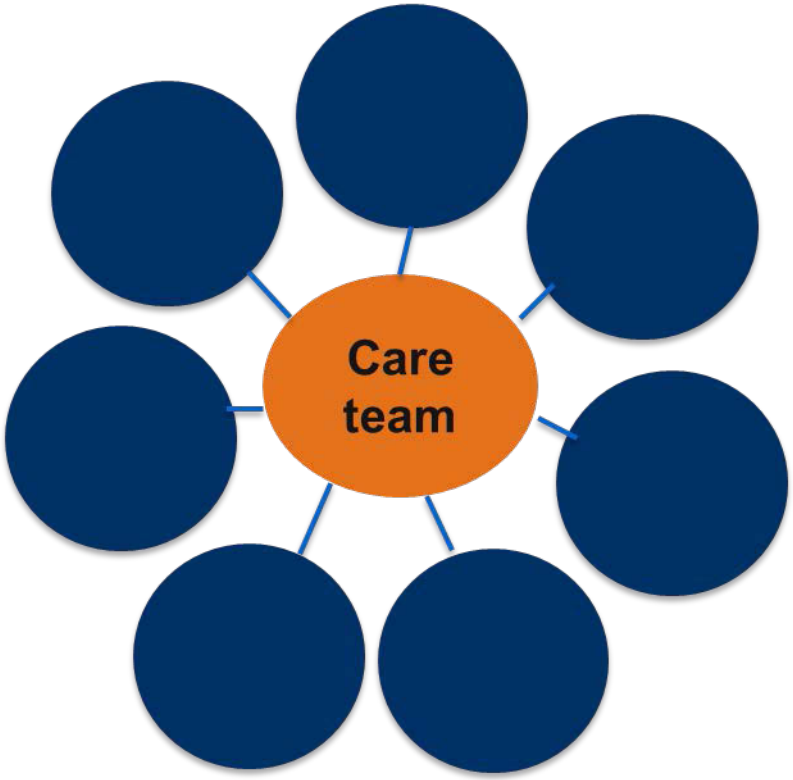
Provides CCEs with:

- Capped number of beneficiaries
- Technical assistance
- Historical and ongoing Medicaid claims data

Financing

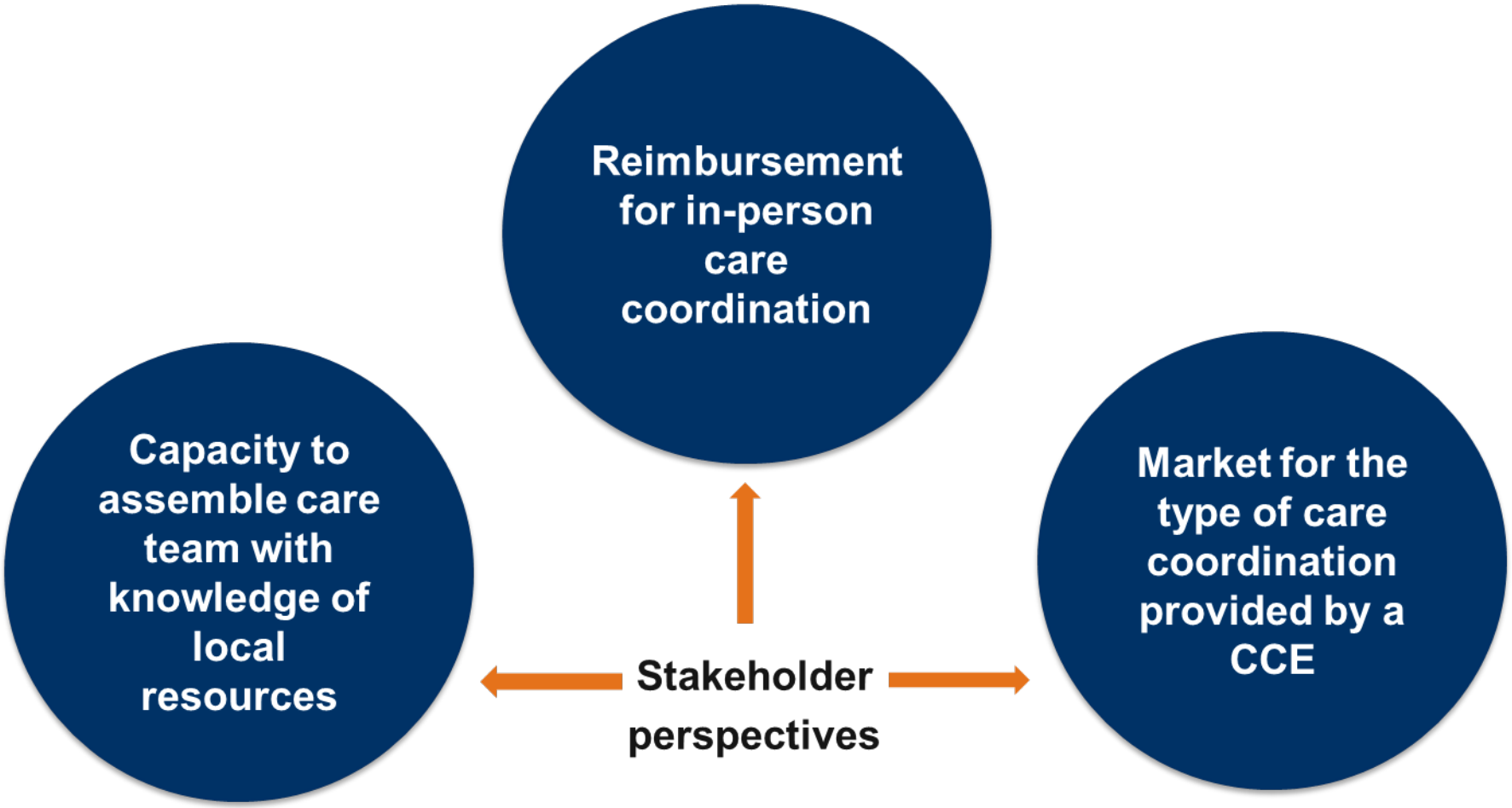
State Medicaid agency	**Medicaid pays the CCE lead agency a per member, per month (PMPM) fee using federal and state funds**
CCE lead agency	**Lead agency uses PMPM fee to cover care coordination costs**
CCE providers	**Medicaid fee-for-service (FFS) reimbursement for everything but care coordination**

Role of Care Coordination Team

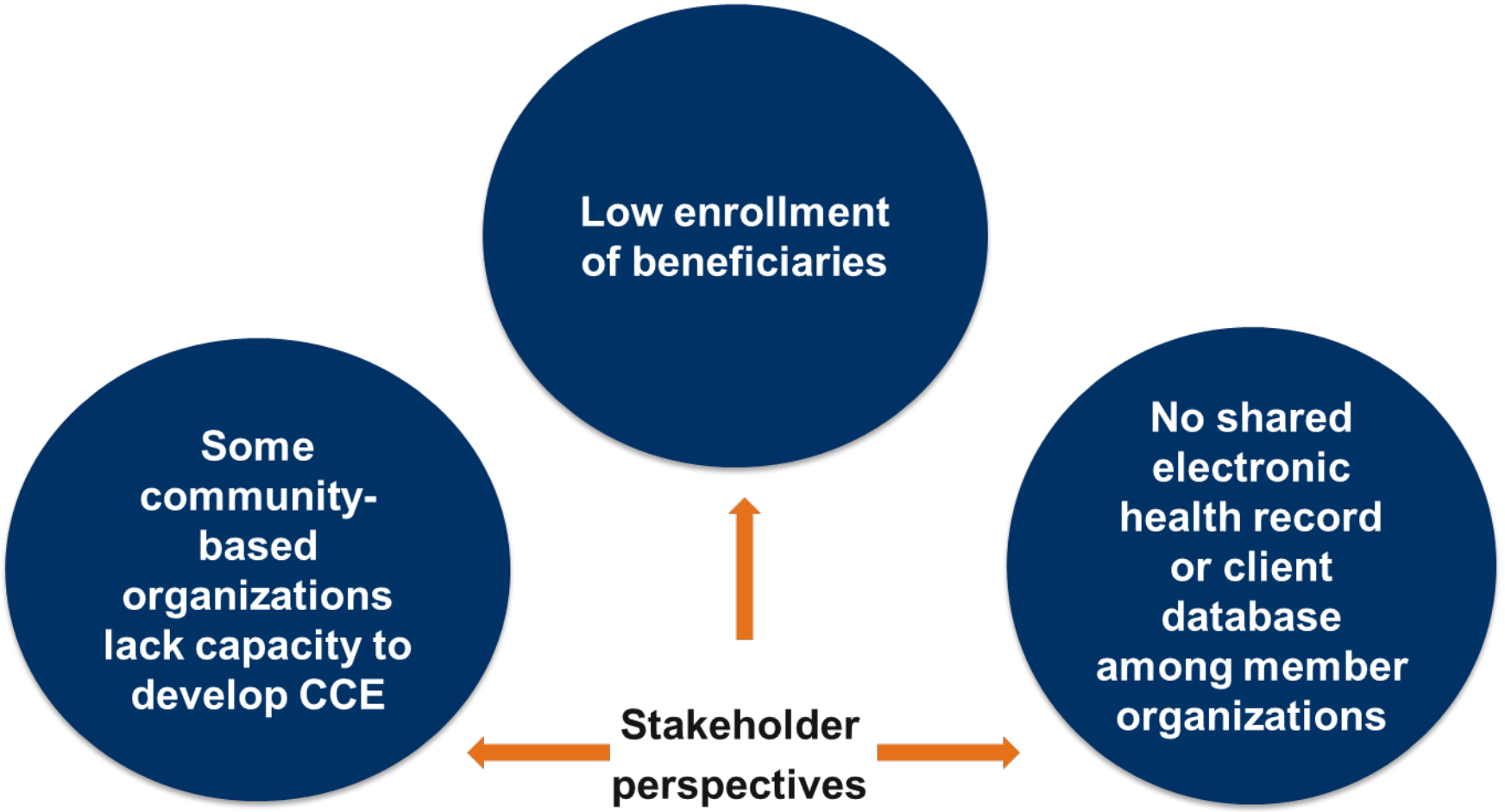


- Reach out to beneficiaries
- Conduct needs assessment
- Connect beneficiaries to CCE member services
- Follow up on treatments, prescriptions, and referrals
- Provide health education
- Teach self-management techniques

Key Ingredients for Coordination



Constraints and Challenges

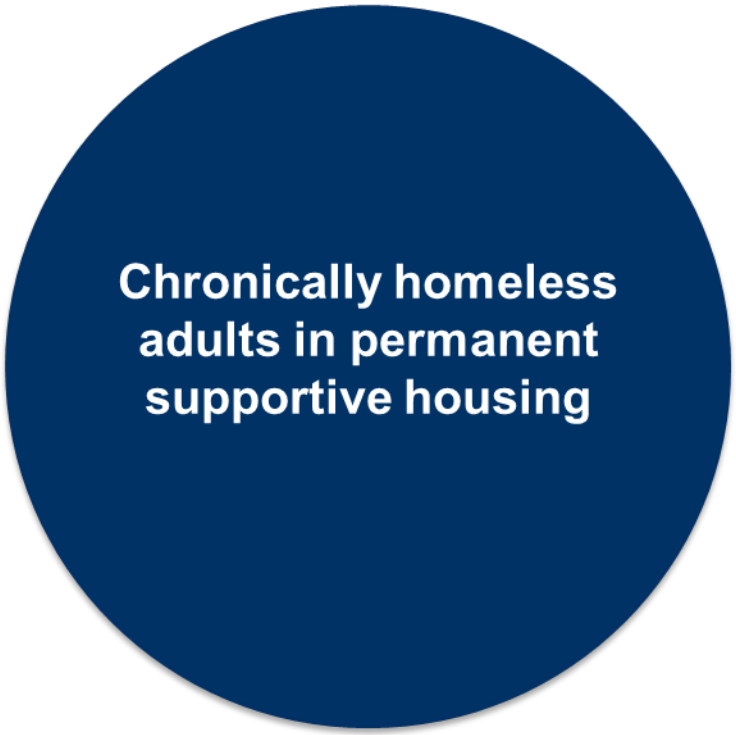


Massachusetts

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 (Medicaid)

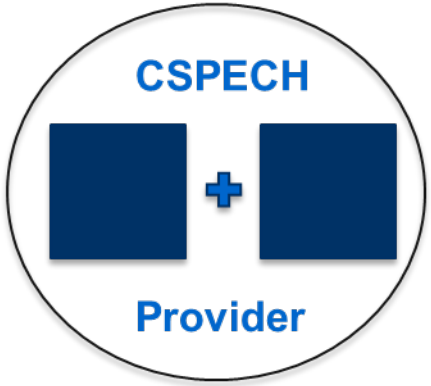
- MassHealth classifies CSPECH as a "community support program" service (a CMS-approved reimbursable service)

MBHP (MBHO)

- 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

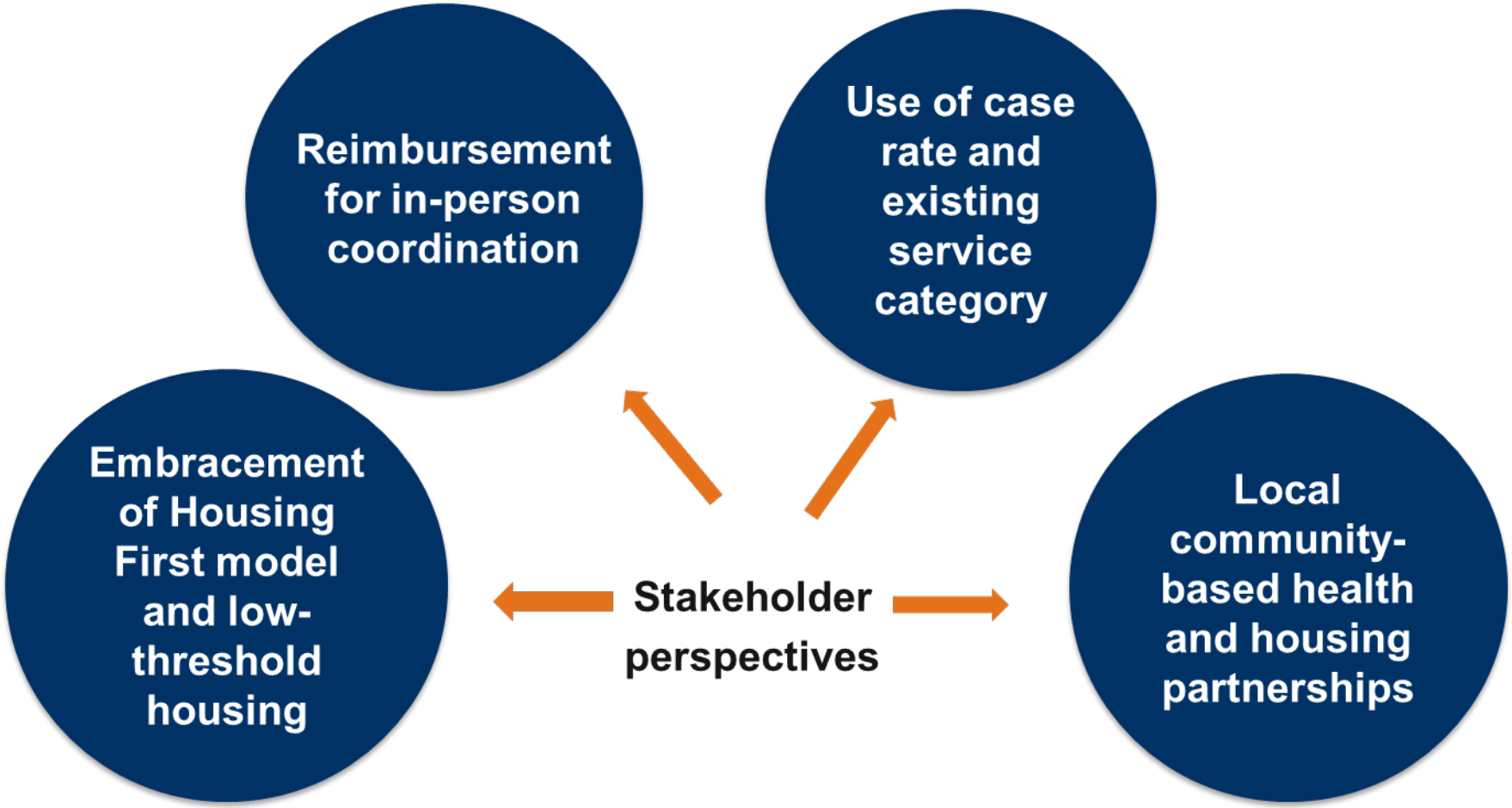
Coordination of Services



Community support worker (CSW)

- 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



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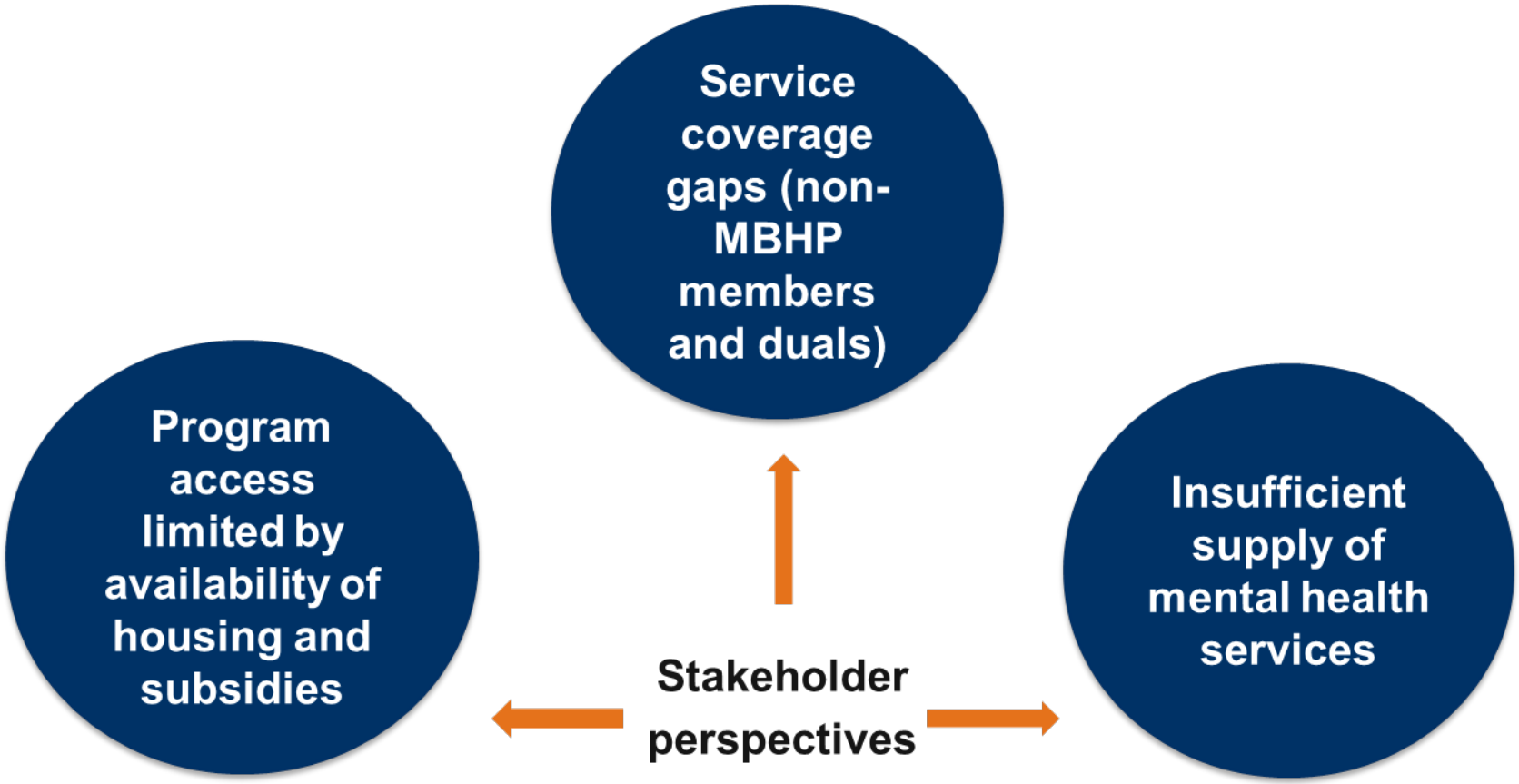

Key Findings

- 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

- Kehn, M., A. Siegwarth, R. Kleinman, and J. Brown. "Improving the Coordination of Services for Adults with Mental Health and Substance Use Disorders: Profiles of Four State Medicaid Programs." Washington, DC: Mathematica, January 2015.

- Siegwarth, A., M. Kehn, R. Kleinman, and J. Brown. "State Strategies for Improving Provider Collaboration and Care Coordination for Medicaid Beneficiaries with Behavioral Health Conditions." Issue brief. Washington, DC: Mathematica, December 2014.

- Kleinman, R., M. Kehn, A. Siegwarth, and J. Brown. "State Strategies for Coordinating Medicaid Services with Housing for Adults with Behavioral Health Conditions." Issue brief. Washington, DC: Mathematica, November 2014.

Discussant

Jennifer Ho

U.S. Department of Housing and Urban Development

Audience Q&A

Jonathan Brown
Mathematica

Carol Irvin
Mathematica

Matthew Kehn
Mathematica

Jennifer Ho
U.S. Department of Housing and Urban Development

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

Mathematica's Center for Studying Disability Policy

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