Managed Care and Housing

Innovation & Collaboration with Managed Care

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Overview

- Need for Housing with the LTSS population
- Housing Barriers
- Collaboration among MCOs and TennCare
- Shift in Care Coordination Approach
- Lessons Learned
- Benefits to MCO Involvement in Housing and MFP
- Member Outcomes

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The Need for Housing in a LTSS Program

- Early experience in the LTSS program indicated that housing was a significant need for LTSS program participants to allow them to remain in their communities.
- Early grassroots collaboration with housing authorities was conducted by Amerigroup to transition members out of the nursing facility.
- Increasing housing needs led to conversations with our existing provider community and TennCare to discuss residential benefit options for members.

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Housing Barriers Encountered

- Finding affordable housing
- Finding both affordable and accessible options
- Frequent issues with member credit/past landlord experiences
- Required identification/documentation
- Criminal background
- Lack of natural supports

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Collaboration with TennCare

- Development of TennCare Housing Specialist
  - Enhanced MCOs knowledge of housing resources and specific housing programs that the population could qualify for.
  - Monthly meetings with the Housing Specialist for review of specific cases provided opportunity to obtain housing for some of the most challenging cases.
- Housing Conference
  - Enhanced networking with housing authorities, providers and developers.

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Collaboration with TennCare

- Housing Steering Committees
  - Coordinates different initiatives among housing authorities and MCOs to ensure best success.
  - Enhances understanding among participants of community needs and matching initiatives to these needs.
  - Encourages collaboration among the MCOs.
- Development of enhanced residential benefits
  - Allows for more options for elderly and disabled program participants.

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Collaboration with other MCOs

- Resource sharing among MCO staff regarding housing opportunities.
- Development of potential roommate matching of members across MCOs needing affordable and accessible housing.
- For residential providers, development of standardized processes across MCOs for ease of providers and housing entities.

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Changes in Care Coordination Approach

- Development of specialized staff at the MCO that focus on housing needs.
  - Required enhancement of systemic tracking and monitoring of housing needs.
  - Assist in identifying trends across service areas and potential opportunities to “match” members for housing.
  - Coordinated focus on enhancing housing connections.

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Changes in Care Coordination Approach

- Training and education with Care Coordination staff regarding housing resources and housing programs, both state and federal.
  - Goal to enhance Care Coordinator's "housing" literacy when educating and assisting members make housing choices.
  - Enhance Care Coordinator skills in assessing member environment and determining when benefits such as home modifications could preserve member housing.
  - Enhance knowledge of how to go about removing barriers.

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Changes in Care Coordination Approach

- Capitalize on the connections of Care Coordination staff that live and work in their communities.
  - Staff have been an invaluable resource in finding local housing that helps member remain in their community and age in place.
  - Additional resource in finding items and furniture needed to transition a member to a new home.

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Changes in Care Coordination Approach

- Development of a housing needs assessment and processes to support identified housing needs.
  - Applying person centered approaches to what the member wants in their living environment.
  - Development of a multi-disciplinary case conference for members requiring housing to evaluate housing options and ensure member fit to mitigate future disruptions.
  - Additionally have a housing action plan to assure appropriate movement and resolution of any barriers.

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Lessons Learned

- Collaboration is key to identifying appropriate housing resources for members.
  - This could be at the macro level with large housing entities or at a more micro level in collaboration with community resources.
- A thorough assessment of member's desires, interests and needs is required to identify appropriate housing and is integral in potential roommate matching.

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Lessons Learned

- The member must lead the planning process for housing and all plans must include the member desires and interests.
  - We had early placements that weren't successful because we didn't execute this as well as we could.
- Planning must include all people involved in member care and support, including care providers, to ensure clarity regarding the plan of care.

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Benefits to changes in MCO approach

- Improved member outcomes
- Enhanced relationships in the housing community leading to the MCO more readily being able to react and respond to housing needs.
  - Housing has historically been a significant disruptor of a plan of care.
- More proactive monitoring of housing stability for members, thereby reducing potential disruptions altogther.

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Member Outcomes

- Significant impact on the ability to transition members from the nursing facility.
- Enhanced assessment of a member's environment and the ability to adapt current environment, if appropriate, minimizing housing needs and member disruption.
- Enhanced ability of staff to more readily identify appropriate housing, avoiding a poor housing match and future housing disruptions.
- Enhanced ability to retain members in their community allowing them to age in place.

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One Member's Story

John is a 64-year-old male with a variety of medical conditions, including hypertension and HIV who had lived in a nursing facility for over 5 years. In conversation with the member, it was determined that the member would need low cost and accessible housing located within walking distance to the clinic where he received treatments for his HIV, which limited housing options significantly. Additionally, John no longer had any identification that would be needed to obtain housing.

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One Member's Story – Action Plan

- The CC, in collaboration with the member, obtained the documentation needed for placement.
- Through collaboration with TennCare and other housing authorities, a low cost option was located for member next to his clinic; however, there were accessibility concerns.
- The CC facilitated the installation of a mechanical stair lift via community resources.
- Additionally, a home modification was completed to modify member's bathroom for safety.

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One Member's Story - Outcome

John was successfully transitioned out of the nursing facility to a home of his own that was located next door to the clinic. Because of the creativity of adapting the environment due to the location being such a significant factor for this member, the member is able to easily access support groups, nutritional supplements, and other necessary services needed and is in his own community.

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Thank you

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Housing and Healthcare
Investments, Experience, and Barriers

Managed Care Organizations and Housing: Realizing the Intersection Between Housing and Health

September 2015

UnitedHealthcare®
COMMUNITY & STATE

Housing – Why do MCOs Care?

- State reliance upon managed care for the most complex populations is continuing to increase
  - LTSS continues to evolve
  - Additional populations require new perspective

- Supporting complex populations requires a broad understanding of the needs and solutions require more than traditional approaches
  - Physical health is sometimes one of the easiest needs to be met
  - Traditional tools only solve part of the challenges

- Addressing clinical needs in a vacuum will only go so far
  - Clinical solutions can be foundational, but are often limited in affecting lasting effect
  - Basic needs can overshadow even the most comprehensive clinical approach

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

Triple aim alignment.*

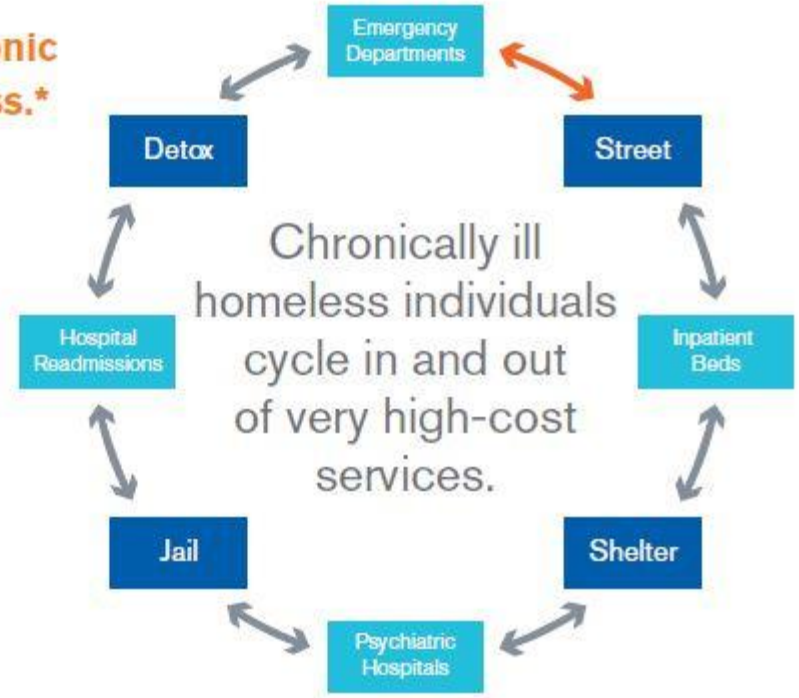
Linking Housing and Healthcare

UnitedHealthcare COMMUNITY & STATE

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.

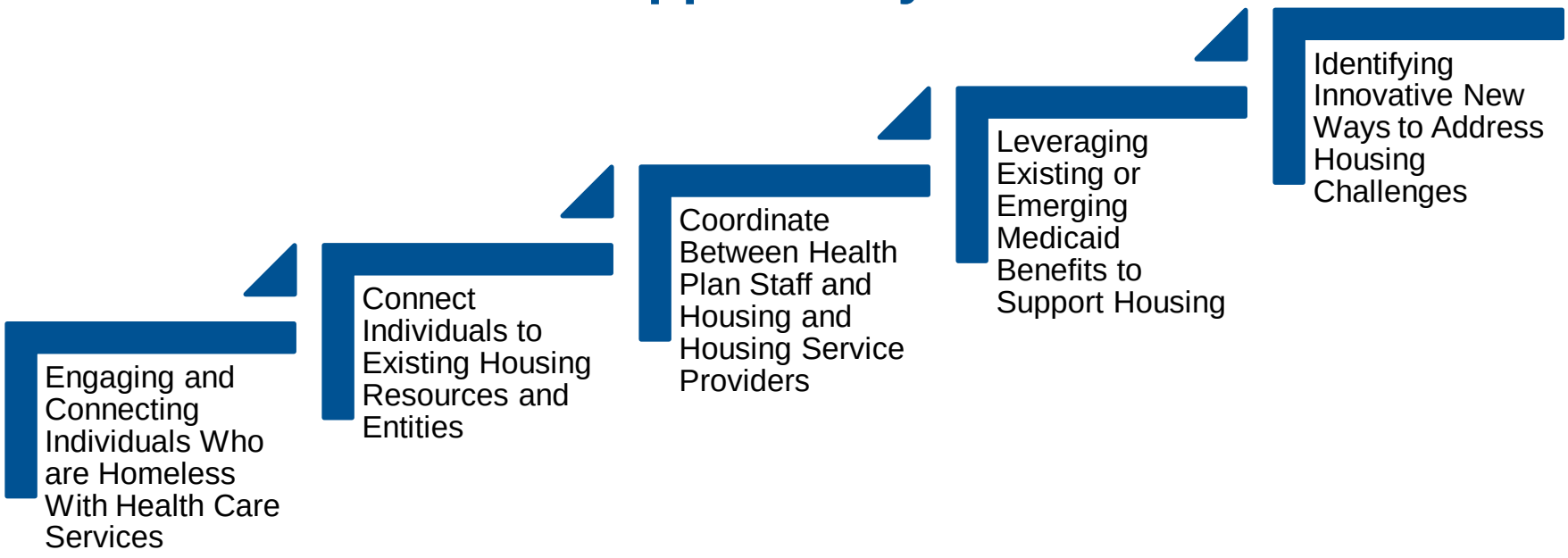
Cycle of chronic homelessness.*



Housing and Healthcare

UnitedHealthcare COMMUNITY & STATE

A Continuum Of Opportunity



Case Study: Texas Chronically Homeless Initiative

UnitedHealthcare COMMUNITY & STATE

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

Case Study: Supportive Housing Collaborations

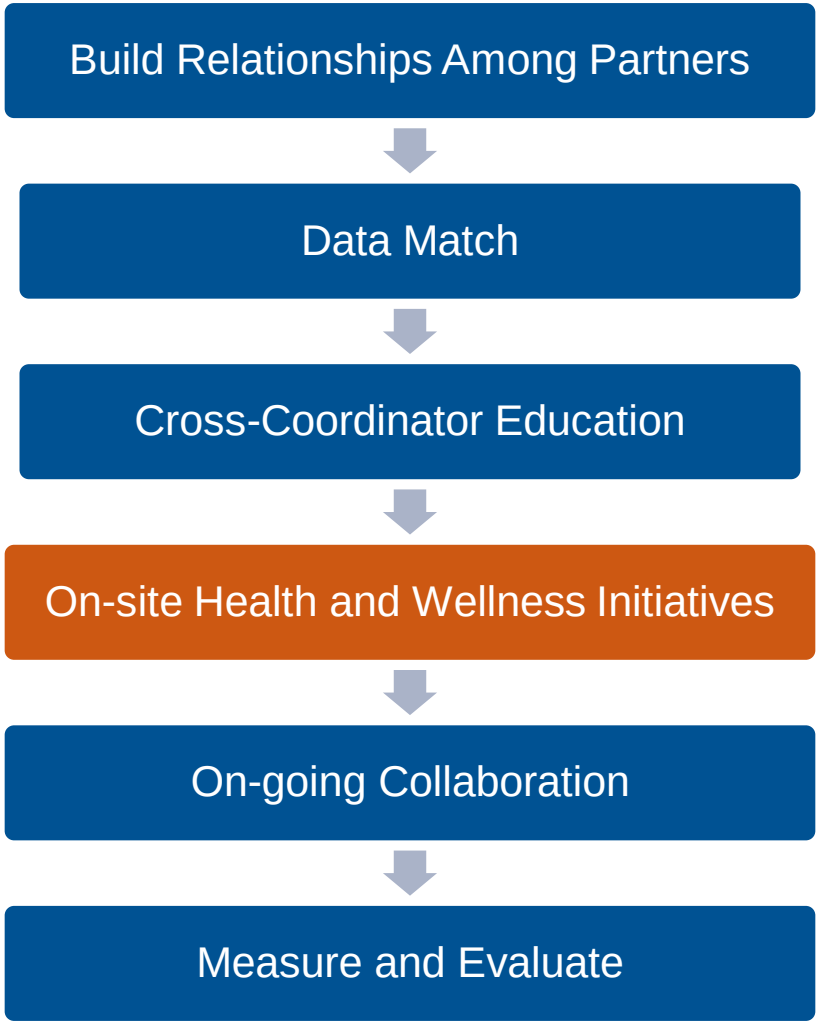
UnitedHealthcare COMMUNITY & STATE

The Vision

- **Partnership with a supportive housing development** with a significant concentration of Medicaid managed care members to create connectivity between residential supportive housing managers and social workers and the managed care coordination team for the beneficiary.

Our Partners

- Low Income Affordable Housing Developers
- Permanent Supportive Housing Providers



Case Study: Initial Conversations

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Opportunity lies in leveraging each entities' strengths to support the needs of the individual we are serving.

Health Plan Strengths

- Accessing and arranging Medicaid services
- Facilitating relationships with providers
- Preparing for transitions from hospitals, nursing homes, institutions
- Providing health and wellness programs
- Assessing risk
- Leveraging data

Supportive Housing Provider Strengths

- One on one support
- Catching early warning signs of health and/or functional changes
- Recognizing changes in social or emotional state
- Support basic needs – food, shelter, employment, residency stabilization

Current Housing Investments

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Housing Coordination

- Repatriation
- Transitions
- Peer supports
- Housing specialists

Homeless Supports

- Location partnerships
- In-field care
- Transitions
- Peer supports

Supporting Existing Housing

- Partnerships
- Augmenting Services
- Specialized Programming
- Wellness

Capital Investments

- New development
- Rehab
- Clinic co-locating

Evaluating Opportunities

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- Countless opportunities to improve the link between housing and health care exist

- 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

Overcoming Barriers

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Numerous barriers exist that limit MCO's investment in housing – some real and some perceived

- Restrictive benefit design
  - Benefits are not always aligned to finding housing solutions for health plan members
  - In lieu of benefits are not allowed or clearly understood
- Funding does not support the investment
  - Capitation does not generally support long-term non-institutionalized housing
  - Limited ability to capture housing expenditures is not universally supported in encounter submissions and rate development
  - Long-term penalties exist in the form of rate efficiencies
- Development timelines difficult to overcome
  - Traditional low-income housing solutions are years in the making
  - Regulatory barriers can often limit create solutions

Division of
Health Care
Finance & Administration

Managed Care and Housing

Tennessee's Innovation & Collaboration with Managed Care

Overview

- Managed Care in Tennessee
- Key Personnel
- Leveraging the Contractor Risk Agreement
- Housing Profile Assessment Report
- Collaboration between MCOs and TennCare's Housing Specialist

Managed Care in Tennessee

- Began in 1994 under the state's 1115 demonstration waiver
- Long-Term Services and Supports carved in 2008 with passage of legislation. CHOICES implemented in 2010.
- Money Follows the Person Demonstration grant awarded in 2011
- 3 Managed Care Organizations operating statewide
  - Amerigroup
  - BlueCare
  - United Healthcare

Key Personnel

- Long Term Services and Supports Division
  - Quality & Administration
    - Money Follows the Person Project Director

      Caitlin Wright

      caitlin.wright@tn.gov

    - Housing and Employment Specialist

      Abigail Dowell

      abigail.dowell@tn.gov

Contractor Risk Agreement

- Assessment, Care Coordination and Care Planning Requirements:
  - Care Coordination
    - The CONTRACTOR shall use care coordination as the continuous process of: identifying the physical health, behavioral health and long-term care services and other social support services and assistance (e.g., housing or income assistance) that are necessary to meet identified needs;
  - Needs Assessment
    - At a minimum, the comprehensive needs assessment shall assess: the physical health, behavioral health and long-term care services and other social support services and assistance (e.g., housing or income assistance) that are needed, as applicable, to ensure the member's health safety and welfare in the community, delay or prevent the need for institutional placement, and to support the member's individually identified goals and outcomes, including employment (as applicable) and integrated community living.
  - Care Plan
    - A description of the member's psychosocial needs, including any housing or financial assistance needs which could impact the member's ability to maintain a safe and healthy living environment and how such needs will be addressed in order to ensure the member's ability to live safely in the community;

Contractor Risk Agreement

- Transition Team Requirements:
  - To fulfill its obligations pursuant to Nursing Facility to Community Transitions and the MFP Rebalancing Demonstration, the Transition Team shall consist of at least one (1) dedicated staff person without a caseload in each Grand Region in which the CONTRACTOR serves TennCare members, who also meets the qualifications of a care coordinator specified in Section A.2.9.6.12. The transition team may also include other persons with relevant expertise and experience who are assigned to support the care coordinator(s) in the performance of transition activities for a CHOICES Group 1 member. Any such staff shall not be reported in the care coordinator ratios specified in Section A.2.9.6.12, and shall be responsible for proactively identifying TennCare members in NFs who are candidates to transition to the community and to further assist with the completion of the transition process specified in Section A.2.9.6.8. All transition activities identified as responsibilities of the care coordinator shall be completed by an individual who meets all of the requirements to be a care coordinator.

Contractor Risk Agreement

- Housing strategy requirements:
  - The CONTRACTOR, in collaboration with TennCare, shall develop a strategy to strengthen networks with housing providers and develop access to affordable housing. The CONTRACTOR shall actively participate with TennCare, other TennCare managed care contractors, and other stakeholders to develop and implement strategies for the identification of resources to assist in transitioning CHOICES members to affordable housing. To demonstrate this strategy, the CONTRACTOR shall report annually to TennCare on the status of any affordable housing development and networking strategies it elects to implement.

Contractor Risk Agreement

- Housing Profile Assessment Report
  - The CONTRACTOR shall submit a Housing Profile Assessment Report quarterly in a format specified by TennCare. This report shall monitor the housing needs of CHOICES enrollees waiting to transition or post-transition and includes, but is not limited to, transition wait times, transition barriers, monthly income amounts, housing options chosen, and counties chosen for transition.
  - The 4th Quarter submission will also include a brief narrative of the CONTRACTOR'S work strategy to create stronger networks and develop easier access to affordable housing.

Housing Profile Assessment Report

- Assesses barriers to housing
  - Mental Health Needs
  - Lack of Natural Support
  - Lack of Affordable Housing
  - Criminal Background Records
  - Lack of Economic Resources
  - Poor Rental History
  - Documentation Needs
- Average monthly income
- Transitions per county

Housing Profile Assessment Report

- Housing options selected by members
  - Single Family Homes
  - Multi-Family Homes
  - Community Based Residential Alternative
  - Non-paying options

- Bedroom needs

- Average time from completed transition plan to actual transition

Collaboration Highlights

- Monthly Housing Calls
  - 1 call for each MCO
  - MCO representatives & TennCare Housing Specialist
  - These calls are specifically geared to discuss housing resources for individuals with greater barriers to transition

Collaboration Highlights

- TennCare Housing Conference
  - 2013 & 2014
  - Provided an opportunity for MCOs and affordable housing providers to learn more about each other
  - Created stronger networks between housing and healthcare
  - Created break-out groups who meet regularly to discuss specific barriers to housing older adults and individuals with disabilities

Collaboration Highlights

- Public Housing Authority (PHA) Road Show
  - An outcome of the 2014 TennCare Housing Conference
  - To enhance connections between PHAs and the MCO Care Coordinators and transition teams
  - Summer 2015 met with the PHAs in Middle Tennessee
  - Fall 2015 will meet with PHAs in East and West Tennessee
  - Resulted in an invitation for care coordinators to attend a yearly statewide PHA conference for further discussion about how we can partner together

Collaboration Highlights

- Regional Housing Steering Committees
  - Collaboration between TennCare, MCOs, Housing and Urban Development (HUD), THDA, Public Housing Authorities (PHA), USDA's Department of Rural Development, Non-profit and for-profit housing providers, Department of Mental Health and Substance Abuse Services (DMHSAS), and AAADs
  - Meet Quarterly in each region
  - Assisted in the development of the housing components of the MFP Sustainability Plan
  - Housing developers on the steering committees regularly seek input from the MCOs present when considering what type of housing they should develop