PERMANENT SUPPORTIVE HOUSING & MEDICAID PROVIDERS

A DESCRIPTION OFTHE HEALTH NEIGHBORHOOD DEMONSTRATION PROJECT

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Permanent supportive housing (PSH) providers interested in diversifying their funding sources may want to consider Medicaid as a way of supporting its services. The complexity involved with administering Medicaid can be a barrier for many PSH providers, however. In response to this issue, Heartland Health Outreach's (HHO) Health Neighborhood (HN) Demonstration Project is implementing innovative ways to help permanent supportive housing providers benefit from Medicaid funding and improve health outcomes for HHO participants without having to take on the burdens of becoming Medicaid billers.

OTHER RESOURCES

Supporting a Healthy Home: An Analysis of Opportunities and Barriers to Medicaid for Permanent Supportive Housing Providers in Illinois (Social IMPACT Research Center) This study documents barriers to accessing the Medicaid system for permanent supportive housing providers in Illinois and calls for reform for Illinois's Medicaid rules.

Illinois's Behavioral Health Transformation Medicaid Waiver Application This waiver could change how supportive housing providers bill services to Medicaid in Illinois.

Summary of State Action: Medicaid and Housing Services (CSH) This document shows actions states and other entities have taken to improve service delivery and financing of the services delivered by supportive housing providers.

Interested in pursuing a similar partnership?
Key considerations include:

Identifying appropriate partners that share your philosophy of care, have expertise serving your population, and can sustain a strong working relationship

Establishing clarity and creating space for successful integration by dedicating sufficient staff resources to the partnership

Implementing formal collaborative processes and clearly delineating the boundaries of collaboration

Defining the legal structure of the partnership based on your particular circumstances and legal needs

Determining the financial arrangement that supports the partnership, whether through hourly billing, case rates, incentive payments, or other options

Tracking and analyzing data to learn from your experiences and make the case for the value proposition of the partnership

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BACKGROUND

The issue: Permanent supportive housing programs combine long-term housing assistance and supportive services to reduce the incidence of homelessness, improve health outcomes, and lower overall health care costs. Grant funding supports a large portion of most PSH programs, although these funds have decreased in recent years. Medicaid can play an important role in funding the service component of PSH programs but administrative complexity deters many programs from taking advantage of this important funding source.

The response: In 2016, Heartland Health Outreach began planning the **Health Neighborhood Demonstration Project** to help PSH programs share Medicaid dollars without going through the cumbersome and expensive process of becoming a Medicaid biller and to create a model that leverages the efforts of health and housing providers. The formal partnerships of HN also allow for stronger collaboration between PSH and HHO staff and improved coordination of care. The model is an effort to show that this deep integration between a traditional health care provider and PSH programs will result in improved health outcomes, an improved participant experience, and lower health costs for HN participants. A formal evaluation of the program is forthcoming in 2018 to 2019.

The context: Illinois's health care system is transitioning toward models of care that integrate services across disciplines and organizations, making the HN model particularly timely. The Illinois Behavioral Health Transformation—an effort by the state of Illinois to increase flexibility in the Medicaid program and better coordinate care—is one example of this transition. Likewise, finite resources and losses of state funding are making it increasingly important for providers to develop closer partnerships.

Among the biggest challenges in realizing deeper levels of integration is **operationalizing and formalizing the details of the partnership** and dividing up the **day-to-day work**. Lessons learned from the creation of HN may be able to help providers begin exploring effective and innovative partnerships.

THE HEALTH NEIGHBORHOOD DEMONSTRATION PROJECT

HHO is a Federally Qualified Health Center (FQHC) in Chicago specializing in providing care to individuals experiencing homelessness. Medicaid is a crucial source of funding for HHO services and HHO has developed the systems and expertise to obtain reimbursement reliably. These systems include electronic health records (EHR), protected health information protocols, processes to credential providers, and an experienced billing department to follow up on rejected claims. HHO has also entered into contracts with the Medicaid managed care organizations (MCOs) that serve the Chicago region.

By nature of its specialization in homeless health care services, HHO has strong working relationships with other homeless service providers in the area, including PSH programs. Many of HHO's participants reside in another organization's PSH program and HHO provides health care services to many PSH residents. HHO intends for closer collaboration under HN to not only marry the billing capacity of HHO as a Medicaid biller with PSH programs, but also to better coordinate care and improve the health and well-being of HHO participants.

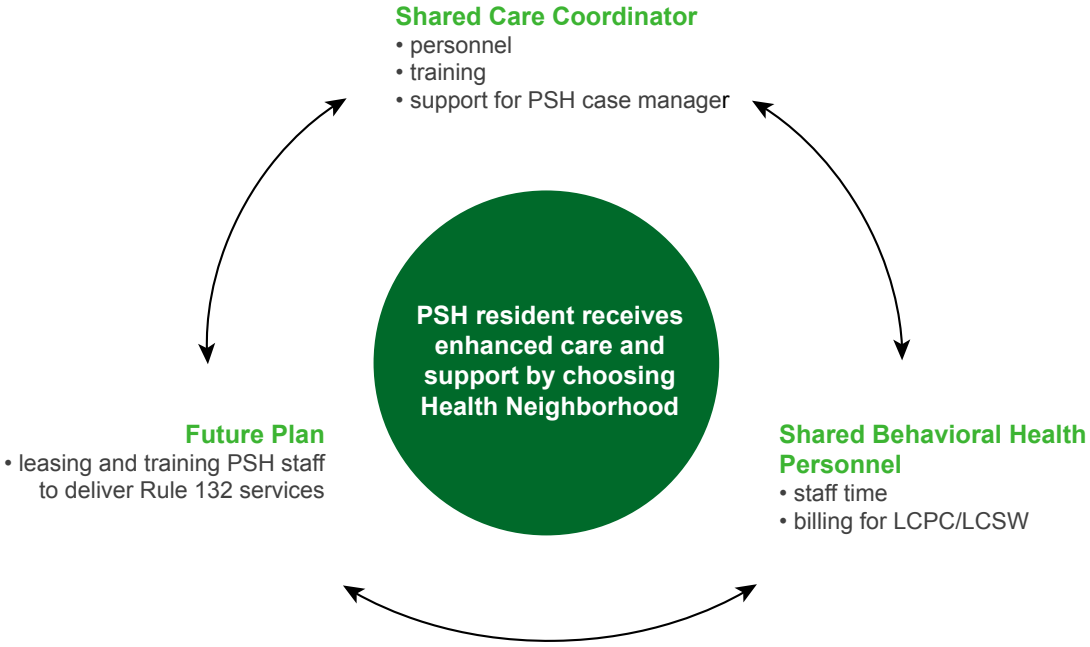
HN PROJECT GOALS

1. *Access Medicaid financing*
2. *Strengthen community partnerships*
3. *Enhance care coordination*
4. *Increase the use of data in service provision*
5. *Improve participant experience*
6. *Improve participant health*
7. *Reduce participant health costs*

Program structure and staffing

At its core, HN is an **agreement between HHO and PSH providers to share staff and collaborate in providing care to PSH residents**. Under this model, shared staff remain employees of the PSH provider, but fulfill job responsibilities and follow procedures laid out by HHO. HHO clinical staff provide supervision for the shared staff, who become part of the care team for that participant. HHO is then able to bill Medicaid for the services provided by those staff that are under its supervision, enabling the partnership to draw down Medicaid dollars to partially fund PSH services. HHO has shared staff agreements with three PSH partner organizations with several more in development.

HN currently has two types of shared staff: **care coordinators** and **licensed clinical therapists**. Each type of staff provides services to a caseload of HN participants made up of PSH residents who are receiving their care from HHO and have signed up to participate. Care coordinators provide medical case management, serve as a liaison between other PSH staff and the HHO care team, and coordinate care with any other outside providers. These services are not currently reimbursable under Illinois Medicaid, but are critical to the effectiveness of other billable health care services. Licensed clinical therapists provide billable units of clinical mental health therapy to those on their caseload. They must be either a Licensed Clinical Professional Counselor (LCPC) or Licensed Clinical Social Worker (LCSW) in order to bill. HHO bills for these therapy services as part of the core services provided by FQHCs, specifically for behavioral health rendered by a licensed clinician. Medicaid providers who are not FQHCs can bill for services rendered by licensed clinicians as well, but may receive a different a Medicaid reimbursement rate and have other reimbursement requirements to submit the claim.



Shared staff receive access to the same trainings, systems, and supports that traditional HHO staff receive. This includes trainings on HHO's philosophy of care and specific clinical skills such as motivational interviewing, trauma-informed care, and harm reduction. HHO places special emphasis on the policies related to protected health information and the Health Insurance Portability and Accountability Act (HIPAA). To ensure eligibility to bill, HHO walks shared staff through all necessary accreditations for Medicaid and MCO billing purposes, and provides medical malpractice insurance through its status as a FQHC.

In order to provide true integration, HN has developed a protocol to **allow shared staff to access HHO's EHR**. To provide access, HHO gives shared staff an encrypted laptop with EHR access and all the needed training on using the EHR, including training on IT security and confidentiality of protected health information. Access to the EHR allows shared staff to see the full chart of their participants, document their own services in that chart, and stay informed about other health services and treatments their participants are receiving. Most importantly, HHO's EHR also automatically generates the claims documentation necessary to bill Medicaid for clinical therapy services. HN participants have access to a patient portal through the EHR system that allows them to access their health information, follow their progress, and manage their appointments. The EHR also allows HN leadership to run reports from the EHR, track HN residents' progress, and course correct as needed.

Funding

HHO pays for shared HN staff and services through a combination of Medicaid billing and philanthropic support. While philanthropic support was critical to getting the model off the ground, Medicaid will support more and more of the project over time.

HN is also exploring leveraging additional Medicaid funding sources to build out the program, including the Rule 132 Medicaid Community Mental Health Services Program. Many HN partners provide services eligible for reimbursement under Rule 132, such as those to help support PSH residents diagnosed with severe mental illness manage their symptoms and retain stable housing. The documentation requirements for this program are very complex and, as of yet, HHO has not been able to develop a shared model that will work. The increased integration, however, has laid the groundwork for HHO and their PSH partners to explore expanding its ability to draw down Medicaid dollars for PSH.

CONSIDERATIONS FOR CREATING INNOVATIVE PARTNERSHIPS

HN may provide a number of partnership lessons and best practices that are easily replicable or that may be adapted to help get new partnerships off the ground. As HN was developed, the following lessons became apparent:

Identify Appropriate Partners

Trusted partnerships are central to the success of this work. Interested PSH programs and other stakeholders should think carefully about what organizations are potential partners. HHO started with PSH programs where they had existing strong working relationships. HHO also ensured that the PSH programs shared some basic principles, aligning with their philosophy of care, and were willing and able to adopt harm reduction and trauma informed treatment modalities. PSH providers should consider partners that, like HHO, are established Medicaid billers with experience with hard-to-serve populations and the capacity to train staff and administer new programming. FQHCs like HHO and safety net hospitals may be strong potential partners for PSH providers.

Establish Clarity and Create Space for Successful Integration

Deeply integrating two organizations is challenging under the best circumstances, so interested parties must set themselves up for success at the start. One important way to do so is by creating clarity and space for successful integration. In times of resource scarcity, it is tempting to spread responsibilities among staff by adding pieces to their existing workload, but developing this level of integration requires attention and oversight. Accordingly, a partnership should establish a project manager or similar lead that manages the project and is the clear point person for troubleshooting throughout the process.

Implement Formal Collaborative Policies

A shared understanding of goals and formal policies that coordinate operations are integral to creating the sort of integration necessary for a successful partnership. Shared PSH staff attend HHO staff meetings, bring challenging residents up for case consultations with the clinical team, and electronically communicate with the HHO treatment team through the EHR. These formal, tangible methods of collaboration are critical to leveraging the opportunities of a partnership like HN. As a part of this, HHO and its partners also had to determine not just where to collaborate, but also the limits of that collaboration. For example, HN determines specifically which participants and staff are part of the collaboration. Staff who are not specifically "shared" under the program do not have any enhanced access to HHO clinical teams or communications channels. This helps ensure quality and controlled management of the program. Any Medicaid and PSH provider partnership should clearly delineate the collaborative practices and participants in this way.

Define the Legal Structure for the Partnership

One of the most complicated pieces of creating HN was the development of a contract between the PSH providers and HHO that protected all parties and allowed for the best care of participants. HHO needed to revise the shared staff agreement several times as the legal team identified new risks. The issues that were most challenging to address were those of liability and indemnification. PSH providers under HN are required to maintain basic professional liability insurance and HHO maintains medical malpractice liability insurance as an FQHC. With a few exceptions, the contract also indemnified HHO from most claims brought for actions conducted by the shared PSH staff. Providers in these partnerships may approach liability and indemnification differently and may have different legal needs. Partnerships should be sure to allow sufficient time and planning to meet the legal needs of both the Medicaid provider and the PSH provider.

Determine the Financial Arrangement

Participating in a partnership such as HN demands staff time and attention. The partners and outside payers need to determine how to compensate for this staff time and how to leverage additional resources to support each partnership organization. HN uses an hourly rate paid by HHO to the PSH partner for the time their staff spend serving HN participants. In most cases, HN shared staff are working with the HN participants for an average of 10 hours per week. HHO then bills Medicaid for the services provided by the shared staff. A monthly case rate or incentive payments for improved outcomes are other approaches to constructing the financial arrangements between partners.

Track and Analyze Data

Most Medicaid providers are already tracking and reporting on a number of existing health measures and stakeholders can use this existing infrastructure to improve services for residents. This data can also play a critical role in making the case for financial support for a PSH partnership.

The data tracked under HN mirrors health goals commonly known in the industry as the triple aim: improving health status, improving the patient experience, and lowering health costs. To track improved health outcomes, staff use a mental health assessment tool and track the regularity of proper hospitalization follow-up. To track improved patient experience, staff have residents periodically fill out satisfaction surveys and track the use of the patient portal through the EHR. Staff track reduced participant cost through appointment show rate, emergency room use, and inpatient hospitalizations.

Organizations considering a similar partnership should take care to identify meaningful outcomes, implement sustainable data collection procedures, and regularly analyze the data in order to learn from their outcomes, course-correct, and make the case for financial support of the partnerships.

HHO is developing a toolkit for organizations who are interested in exploring collaboration such as Health Neighborhoods. The toolkit consists of the shared staff agreement, job descriptions, orientation and training checklists, and more. Please contact Health Neighborhood Project Manager, Cara Pacione, if you would like to learn more at cpacione@heartlandalliance.org.

ADDITIONAL OPPORTUNITIES FOR INNOVATION

The Medicaid and PSH landscape is ever evolving and a number of opportunities to better leverage Medicaid dollars for PSH may be on the horizon:

Value-Based Contracts

The State of Illinois evaluates Medicaid MCOs through a number of quality metrics that measure improvements in health status, enrollee satisfaction, patient follow-up, and more. MCOs are eligible to receive incentive payments if they meet certain quality goals and place special emphasis on achieving those goals. If HN and similar models like it are able to make the types of improvements that can help MCOs draw down these incentive payments, value-based contracts between such partnerships and the MCO may provide an additional source of revenue. This makes it especially important for organizations participating in similar partnerships to implement sound data collection and analysis procedures that shed light on the metrics that matter to MCOs.

Illinois Behavioral Health Transformation Medicaid Section 1115 Waiver

In 2016, Illinois submitted a Medicaid Section 1115 Waiver to the federal government proposing to pilot new Medicaid benefits for beneficiaries struggling with behavioral health concerns. Tenancy supports are one of the new services proposed in the waiver. If Illinois receives approval for the waiver, these services, like the clinical services under HN, would be eligible for Medicaid reimbursement. Depending on the implementation rules, partnership arrangements like HN may be preferable to PSH providers over becoming Medicaid billers themselves.

Integrated Health Home Proposal

Illinois also plans to establish an Integrated Health Home (IHH) program that could provide financial support for integrated care models like HN. The goal of the IHH model is to financially support improved integration and coordination of care in the Medicaid program. Accordingly, it provides enhanced Medicaid funding for services such as care planning and monitoring, population health management, member engagement and education, supportive service coordination, and others that coincide with the duties of the HN care coordinator. An HN model, which centers on deep integration, would help PSH staff to integrate with other parts of the IHH team and other health providers as a part of providing on-site services.

As the Illinois health and human service system becomes more integrated, and the need to best leverage resources continues to increase, deep and formal partnerships like HN may lead the way. While each partnership will collaborate differently, the lessons learned from HN provide some key tools for entities interested in beginning a similar journey.

RESEARCH NOTES

This brief was compiled through interviews with HHO staff responsible for the design and implementation of Health Neighborhood, legal and Medicaid compliance, staff credentialing with Medicaid managed care organizations, Medicaid managed care contracting, behavioral health clinical leadership, and project management. Researchers also analyzed relevant program documents, including contracts between HHO and partner organizations, policies and procedures governing HN, and strategic plans. In order to provide context on potential opportunities for the field, researchers assessed developments in the Illinois Medicaid landscape, including proposed administrative rule changes. The icons included in this brief were retrived from the Noun Project, specific attribution is as follows: magnifying glass created by Mello, houses created by Andrew Doane, hands created by Artem Kovyazin, lightbulb created by ICONCRAFT, people created by romzicon.

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