The Partnership Between Medicaid & Housing Services

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Housing as a Human Right: From Innovation to Impact

October 9, 2024

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Housing as a Human Right: From Innovation to Impact
October 9, 2024

RUTGERS

Connecting Health and Homeless Services for Medicaid Beneficiaries

Presentation to Monarch Housing Associates Conference

Housing as a Human Right: from Innovation to Impact

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We thank Rutgers colleagues Dan Treglia, John Palatucci, and Margaret Koller for their advice, insights, and support.

We are grateful our project **Steering Committee** members from the community, service organizations, and state agencies for their advice and guidance.

The content of this presentation is solely the responsibility of the authors and does not necessarily represent the official views of the Robert Wood Johnson Foundation, National Institutes of Health, the NJ Division of Medical Assistance and Health Services or the NJ Housing and Mortgage Finance Agency.

Outline

- Our Team
- Study Overview
- Voices of people experiencing homelessness (PEH) with health care challenges
- Data on health and homeless service utilization among Medicaid-enrolled PEH

Our Team

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Project Overview

Goals

- Promote collaboration between homeless services and health care providers
- Engage policymakers and other stakeholders to reduce barriers to better care for PEH

Study Activities

- Interviews to learn from **voices of PEH and health care challenges**
- Interviews to describe experiences of **people developing cross-sector programs**
- **Data visualizations** to identify opportunities to promote action to address homeless services gaps

Project Overview

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- **Data visualizations** to identify opportunities to promote action to address homeless services gaps

Findings

VOICES OF PEOPLE EXPERIENCING HOMELESSNES AND HEALTH CARE CHALLENGES

Data Collection

- N=23 interviews
- Conducted July 2023-February 2024
- Inclusion criteria: People who are experiencing or have recently experienced homelessness and have dealt with complex health needs within the healthcare system

Research Questions

1. What challenges do unhoused people with complex health needs experience when navigating services at the intersection of healthcare/housing?

2. What strategies do they identify for improving services at the intersection of healthcare/housing?

Challenges

- THEME 1 - Personal priorities not always aligned with system priorities/resources
  - “*My immediate concern was housing, not veterans’ affairs. My immediate concern was housing, it wasn't my health. My health was secondary.”*
- THEME 2 - Cross-sector experiences occur, but seamless integration between housing/health systems has yet to be realized
  - “*I didn't expect them to even ask like, why are you asking [about healthcare?] when I need housing?”*
  - *Interviewer: In the housing service providers that you've been involved with, have you ever been asked whether you needed help with health care?*
    Interviewee: “That's more, yeah, that's more likely to happen.”

Challenges

- THEME 3 – Programmatic and provider-related barriers to services and integration
  - *“It's just, you know, to make an appointment with a specialist in my insurance plan, I gotta schedule out a whole half a day or even a whole day for 10 minutes with the doctor, for him to write a prescription.”*
- THEME 4 - Some supports are positive but can’t solve systemic failures
  - “*How do you live on $700 with two children?”*
  - *“There's no way out of this loop of hospital and shelter, hospital and shelter.”*

Strategies

- THEME 1 – Modernizing and centralizing care
  - *“We are in 2023. We are still living in the 1990s on resources and paper and scanned in PDF.”*
  - *“I know people that have Section 8 housing vouchers, but they don't know who to talk to about getting the housing. And talk to one person and they'll give them the runaround and, you know, they give them numbers to another place.”*

- THEME 2 - Prioritizing hassle-free in-person care, with virtual options as needed
  - *“They really don't want you coming in there to social services. They want you to do everything over the phone and everything online.”*
  - *“Well, the thing is you have to go, you have to figure out a trip plan…I gotta schedule out a whole half a day or even a whole day for 10 minutes with the doctor, for him to write a prescription.”*

Strategies

- THEME 3 – Increased sensitivity from providers and other efforts to decrease stigma against service recipients
  - *“The staff really doesn't treat us good, but I feel like I'm an animal sometimes, the way they treat us, and the way that they talk to us.”*
  - *“They don't even want to give you medication. You just suffer because of your situation. If you're homeless, they really don't want to give you anything.”*
  - *“I get treated differently sometimes because of the fact that I am a black single mother, and I don't have the male counterpart to assist me.”*

Discussion
Voices of People Experiencing Homelessness

- Impacts of COVID-19 -- Tension between modernizing and returning to in-person services
- Services are most impactful when targeted to the individual and coming from capable, sensitive providers
- Systemic challenges both compromise service delivery and pit people against one another for services – cross-sector services should be designed with this in mind
- Further research is needed to identify specific gaps in different sectors

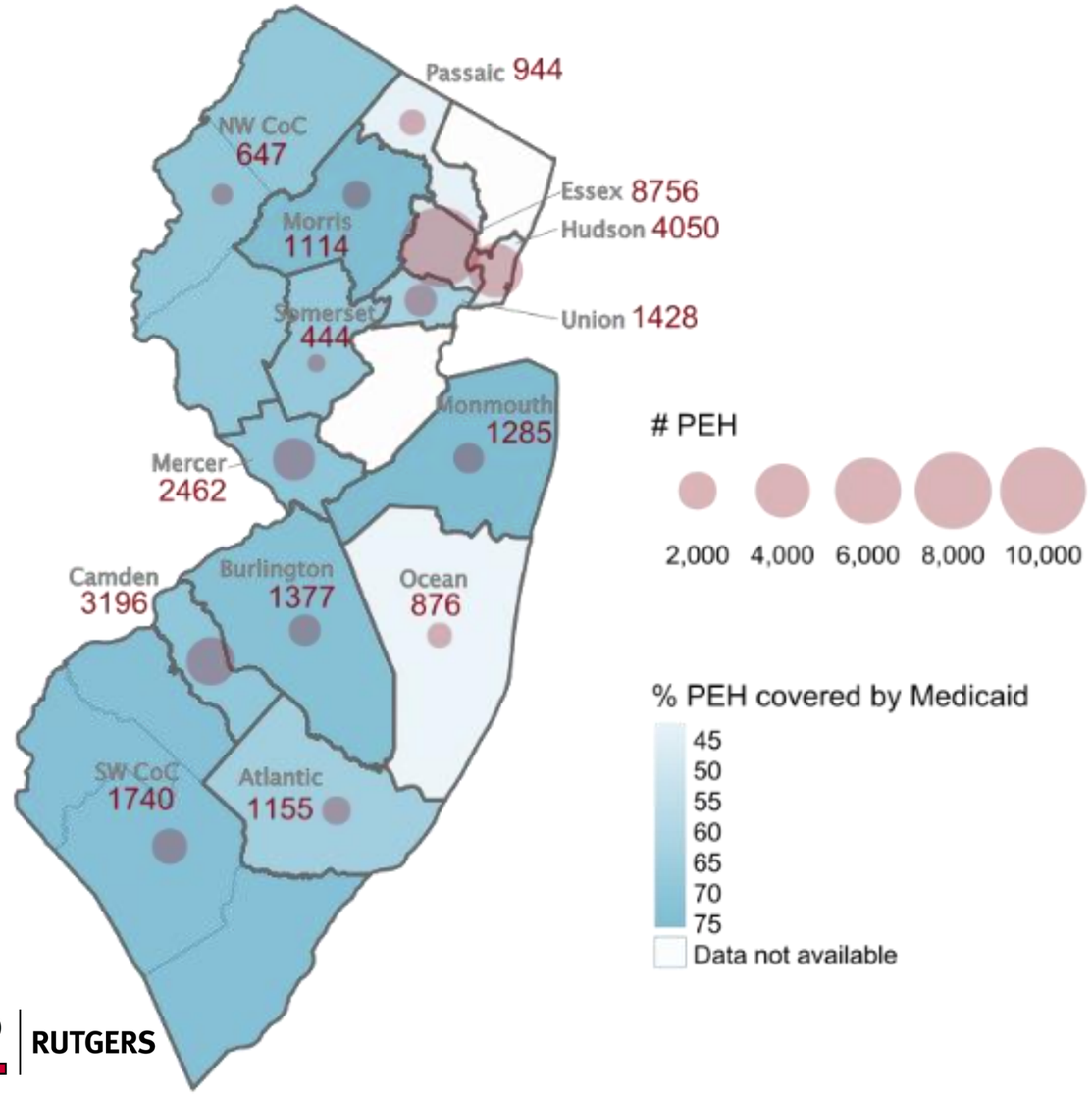
Findings

DATA VISUALIZATIONS

What We Did

- Link Homeless Management Information System (HMIS) data to Medicaid claims/encounter records for 2022
  - Client-level linkage
  - 19 of 21 counties (exclude Bergen and Middlesex Cos)
- Limit to adults, age 18+
- People experiencing homelessness (PEH) defined as users of any of five HMIS-recorded services during the year
  - Emergency shelter
  - Day shelter
  - Safe haven
  - Street outreach contact
  - Transitional housing
- Most analyses limited to Medicaid-enrolled PEH
- Data shown by modified HUD Continuums of Care (CoCs) & for selected hospitals
- Health measures drawn from Medicaid data

Homeless Service Users and Medicaid Enrollment Across CoCs



CoC	County	# PEH	PEH Covered by Medicaid #	PEH Covered by Medicaid %
NJ-509	Morris	1114	845	75.9%
NJ-508	Monmouth	1285	971	75.6%
NJ-503/512	SW CoC [2]	1740	1274	73.2%
NJ-502	Burlington	1377	1005	73.0%
NJ-514	Mercer	2462	1717	69.7%
NJ-503C	Camden	3196	2217	69.4%
NJ-516	NW CoC [3]	647	447	69.1%
NJ-513	Somerset	444	301	67.8%
NJ-500	Atlantic	1155	742	64.2%
NJ-515	Union	1428	890	62.3%
NJ-504	Essex	8756	4186	47.8%
NJ-511	Passaic	944	404	42.8%
NJ-506	Hudson	4050	1665	41.1%
NJ-510	Ocean	876	358	40.9%
All CoCs [1]		29540	17022	All CoCs: 57.8%

[1] Excludes Bergen and Middlesex counties
[2] SW CoC includes Gloucester, Salem, Cumberland, and Cape May counties
[3] NW CoC includes Warren, Sussex, Hunterdon counties

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Prevalence of Behavioral Health and Other Chronic Condition Diagnoses, per 1,000 PEH

CoC*	Serious mental illness (SMI)	Substance use disorder (SUD)	3+ non-BH chronic conditions
Burlington	200	252	75
Mercer	391	476	101
SW CoC[2]	412	478	106
Somerset	455	488	59
Union	378	407	130
Hudson	422	483	124
Passaic	435	485	121
NW CoC[3]	467	498	109
Essex	472	516	114
Monmouth	491	530	128
Ocean	634	608	108
Morris	536	578	124
Camden	497	544	159
Atlantic	598	675	142
All CoCs[1]	449	500	119

Top quartile (lowest)*
2nd quartile
3rd quartile
Bottom quartile (lowest)

*Shorted by highest to lowest mean rank for individual measures

[1] Excludes Bergen and Middlesex counties

[2] NW CoC includes Warren, Sussex, Hunterdon counties

[3] SW CoC includes Gloucester, Salem, Cumberland, and Cape May counties

Key Takeaways

- High rates of SMI, SUD and multiple chronic conditions in all CoCs.
- Wide variation across CoCs in SMI (2.2-fold), SUD (1.7-fold) and multiple chronic conditions (1.7-fold).
- CoCs high in one type of morbidity tend be high the other two.

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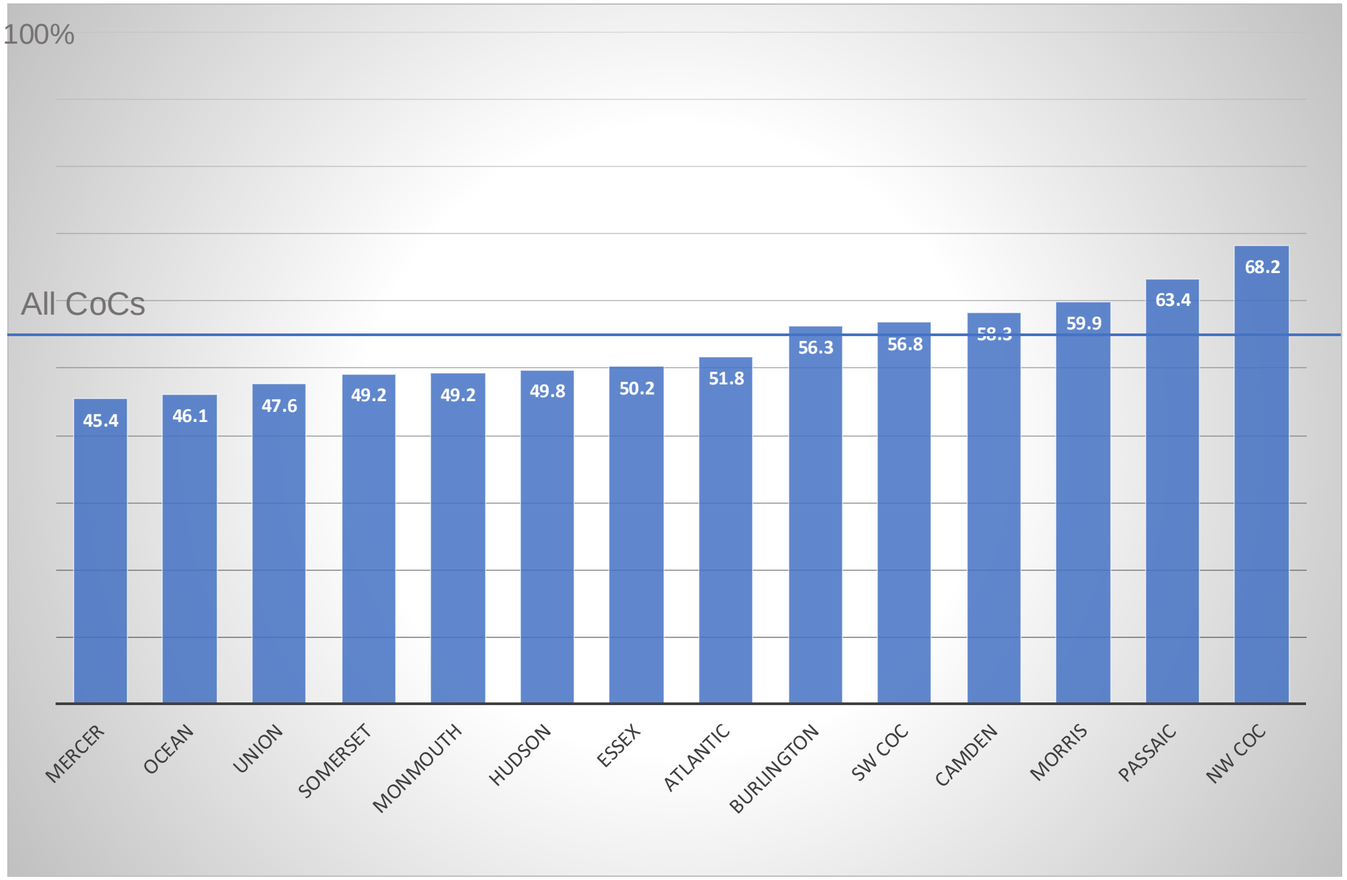
Percentage of PEH with at Least One Primary Visit



Excludes Bergen and Middlesex counties
NW CoC includes Warren, Sussex, Hunterdon counties
SW CoC includes Gloucester, Salem, Cumberland, and Cape May counties

Key Takeaways

- Room to improve Primary Care access in all CoCs.
- Highest region (NW CoC) has primary care visit rate 1.5 times greater than lowest region (Mercer Co).

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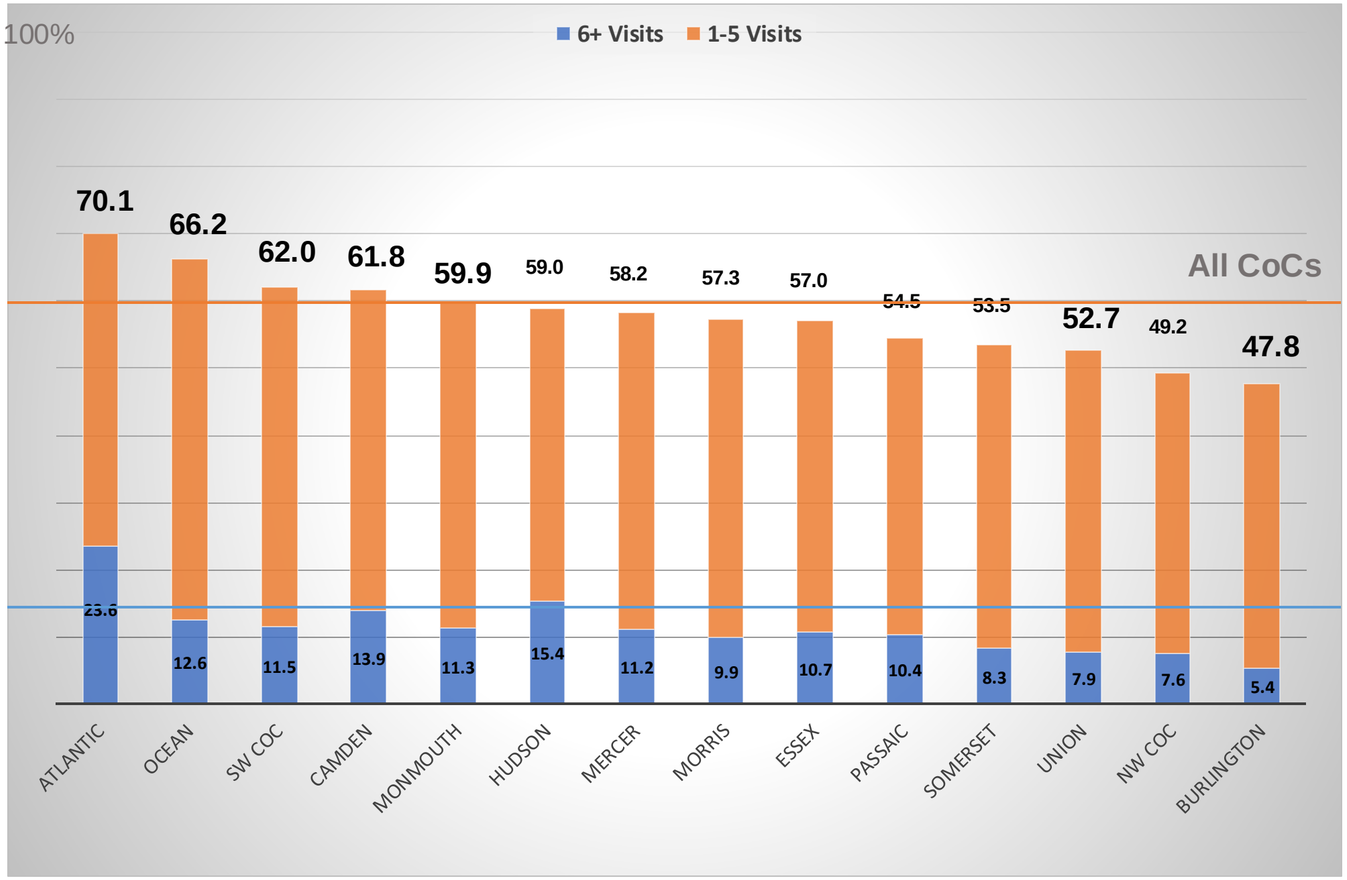
Percentage of PEH with Emergency Department (ED) Visits, Any and Frequent Utilization



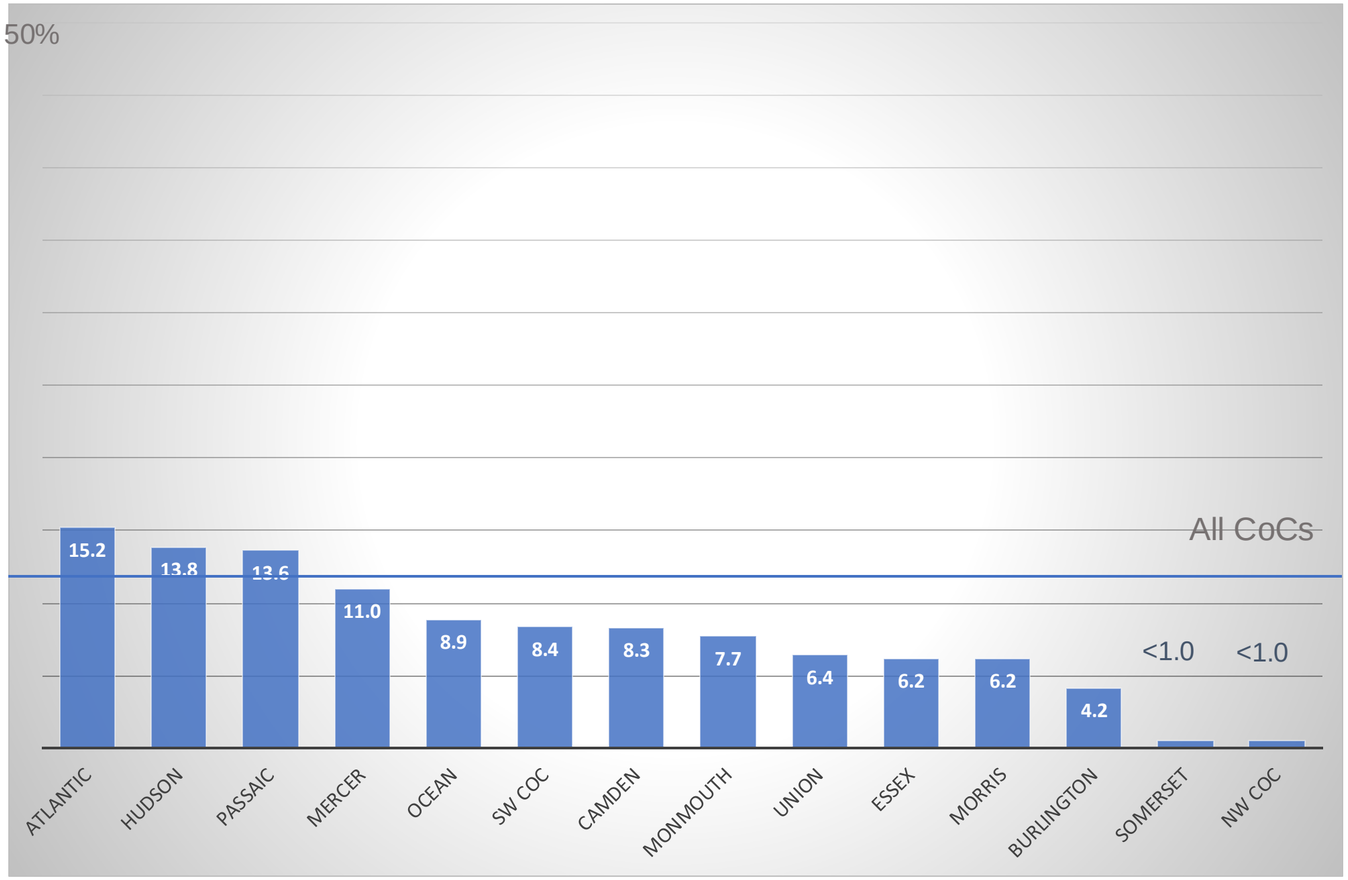
Key Takeaways

- In most CoCs, over half of PEH visited an ED at least once.
- Atlantic Co. stands out as having the highest frequent ED use rate, nearly 1 in 4 PEH.
- Atlantic, the highest region, had an overall ED visit rate 1.5 times higher than Burlington, the lowest region.
- Hudson, Camden, and Ocean also have above average frequent ED use rates.

Excludes Bergen and Middlesex counties
NW CoC includes Warren, Sussex, Hunterdon counties
SW CoC includes Gloucester, Salem, Cumberland, and Cape May counties

RUTGERS

Percentage of PEH ED Users with a Shelter Admission or Street Outreach Contact* within 72 Hours



Excludes Bergen and Middlesex counties
NW CoC includes Warren, Sussex, Hunterdon counties
SW CoC includes Gloucester, Salem, Cumberland, and Cape May counties

Key Takeaways

- Wide variation in the share of ED users returning to homeless services across CoCs.
- Atlantic, Hudson, Passaic and Mercer have over 10% of PEH ED users returning to a homeless service within 72 hours.

*About 90% shelter, 10% street outreach

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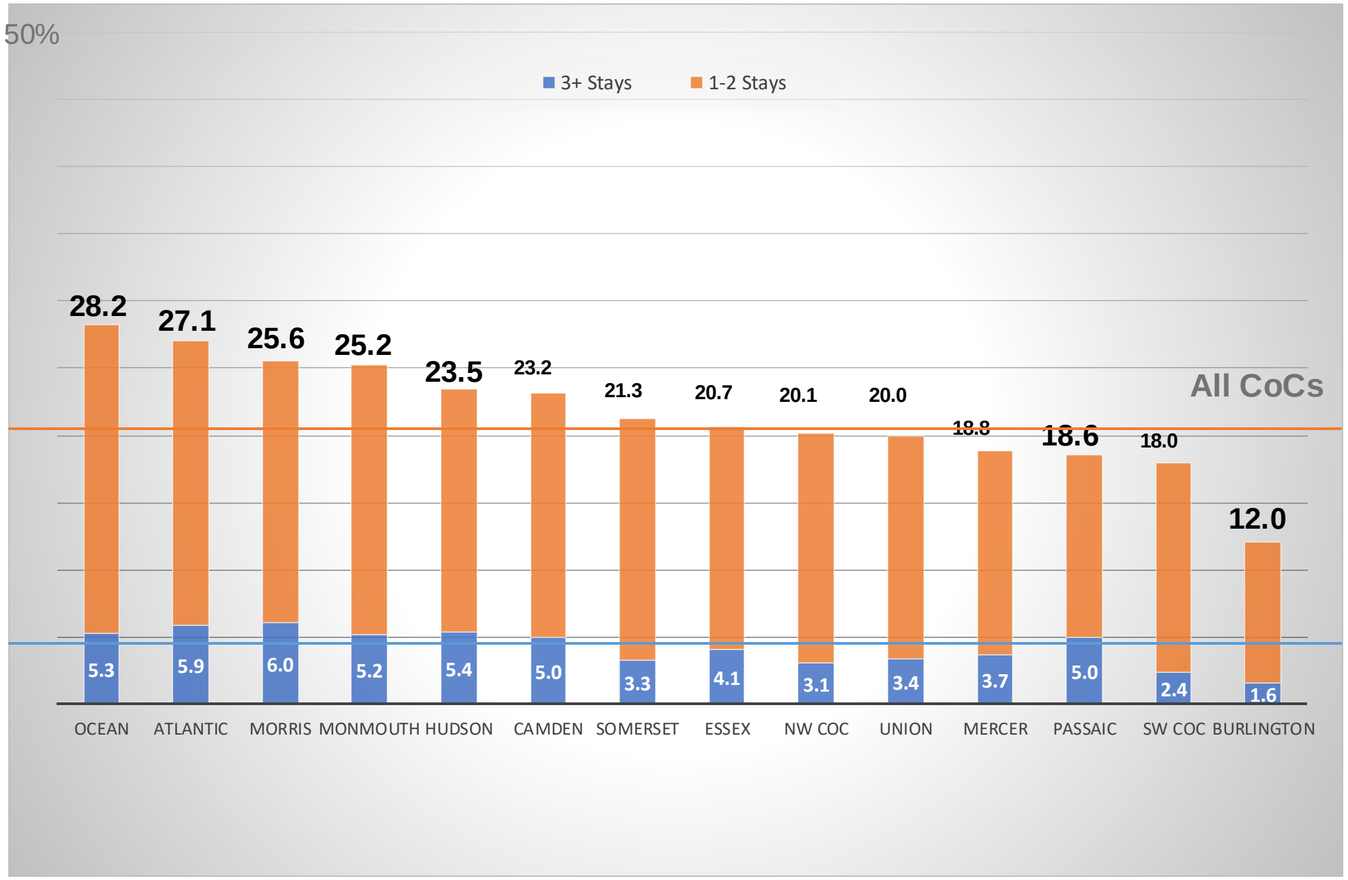
Percentage of PEH with Hospital Inpatient Stays, Any and Frequent Utilization



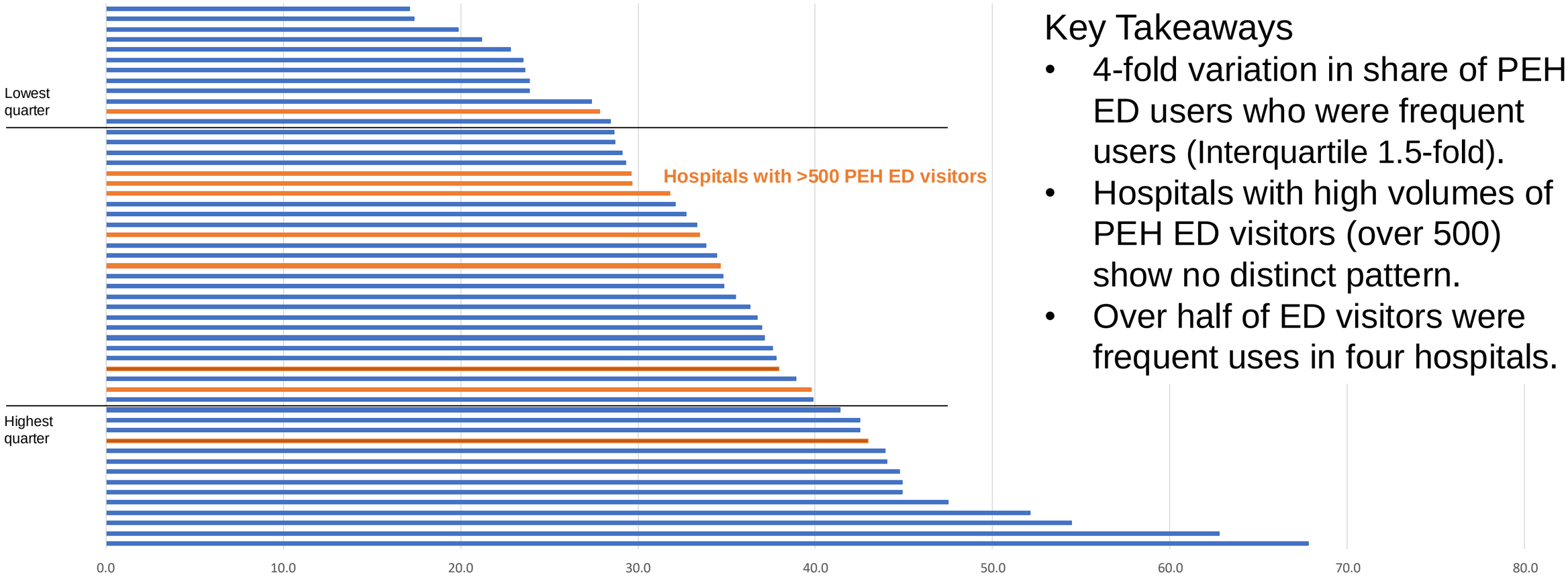
Key Takeaways

- One in five or more PEH are hospitalized at least once across most CoCs.
- Hospitalization rates vary two-fold across CoCs (1.5-fold excluding Burlington).
- 1 in 20 or more PEH were hospitalized frequently (3+ stays) in about half of the CoCs.

Excludes Bergen and Middlesex counties
NW CoC includes Warren, Sussex, Hunterdon counties
SW CoC includes Gloucester, Salem, Cumberland, and Cape May counties

RUTGERS

Percentage of PEH with at Least One ED Visit Who Made Frequent (6 or more) Visits



Key Takeaways

- 4-fold variation in share of PEH ED users who were frequent users (Interquartile 1.5-fold).
- Hospitals with high volumes of PEH ED visitors (over 500) show no distinct pattern.
- Over half of ED visitors were frequent uses in four hospitals.

Excludes hospitals located in Bergen and Middlesex counties
The number of PEH with any ED visits in the facilities in the chart range from about 35 to 1,200.

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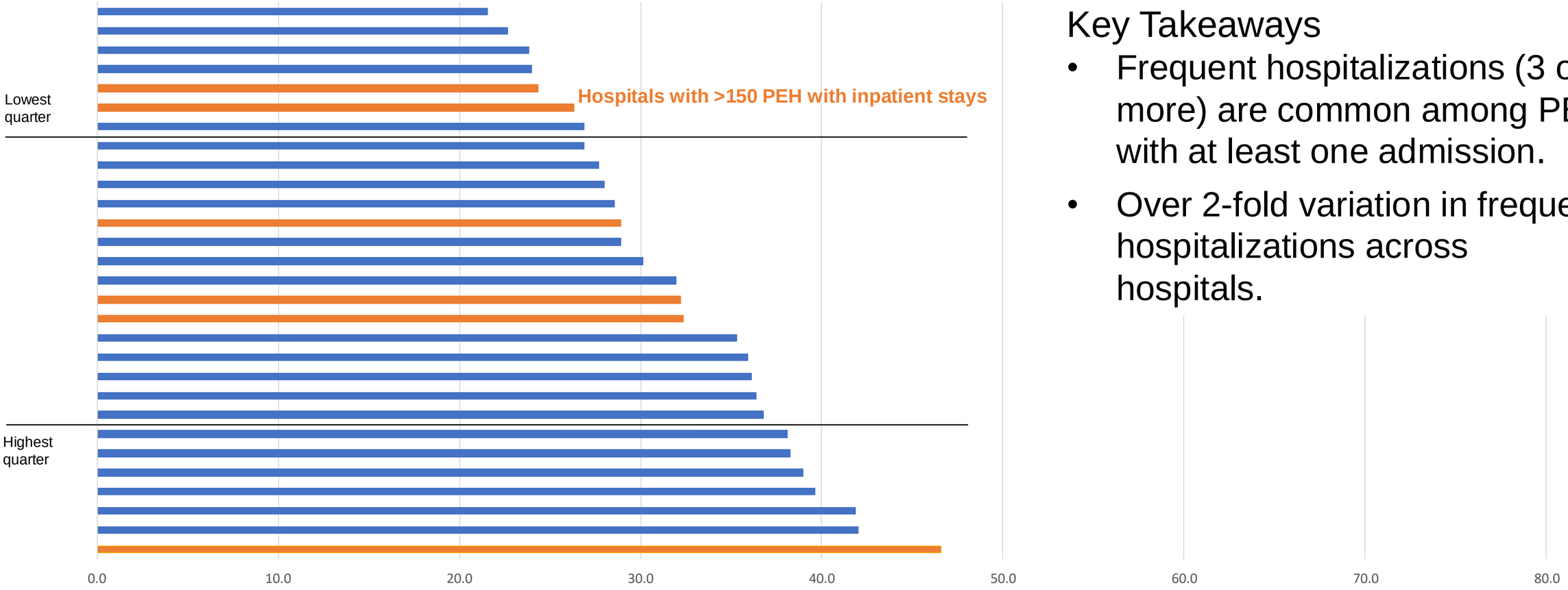
Percentage of Hospitalized PEH who Had 3+ Stays

Hospitals with admissions of at least 30 PEH



Key Takeaways

- Frequent hospitalizations (3 or more) are common among PEH with at least one admission.
- Over 2-fold variation in frequent hospitalizations across hospitals.

Excludes hospitals located in Bergen and Middlesex counties

The number of PEH hospitalized at least once in facilities represented in the chart ranges from about 35 to 400.

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Discussion
Medicaid-Homeless Services Data Visualizations

- Very high and widely varying rates of poor outcomes
  - Frequent ED and inpatient use
  - Return to homeless services after health care encounter
  - Gaps in primary care
- Outcomes may not reflect “performance” of hospitals and community organizations, many other factors may influence outcomes
  - Client/case mix
  - Service mix (e.g., more street outreach → higher rates of return to homeless services)
- Still – high rates of poor outcomes underscore opportunities for health and homeless services organizations to collaborate for better outcomes for Medicaid-enrolled PEH

Additional Analyses Underway

- Use of **community-based mental health and substance use services** among PEH with relevant conditions
- Additional **hospital-level metrics**, e.g., 30-day readmissions, return to ED, spending on inpatient and ED services for PEH
- **Compare HMIS and Medicaid** identification of developmental disabilities and mental health and substance use disorders among PEH, and Medicaid coding of homelessness (ICD-10 code Z59.0)

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Housing as a Human Right: From Innovation to Impact

October 9, 2024

NEW JERSEY HUMAN SERVICES

Housing Supports Program Overview

Monarch Housing as a Human Right: From Innovation to Impact Conference

10-9-2024

Intro to NJ FamilyCare and 1115 waiver

NJ FamilyCare 101

- NJ FamilyCare is the state's Medicaid program which is a federally and state funded health insurance program created to help qualified residents of any age access affordable health care
- Over 1.8 million (20%) NJ residents are enrolled
- There are five managed care organizations (MCOs) that partner with NJ FamilyCare: Aetna, Fidelis, Horizon, United, and Wellpoint
- Nearly all members are enrolled in managed care
- NJ FamilyCare's comprehensive health coverage program provides a wide range of services including doctor’s visits, hospital services, prescriptions, tests, vision care, mental health care, dental, nursing home care, and others

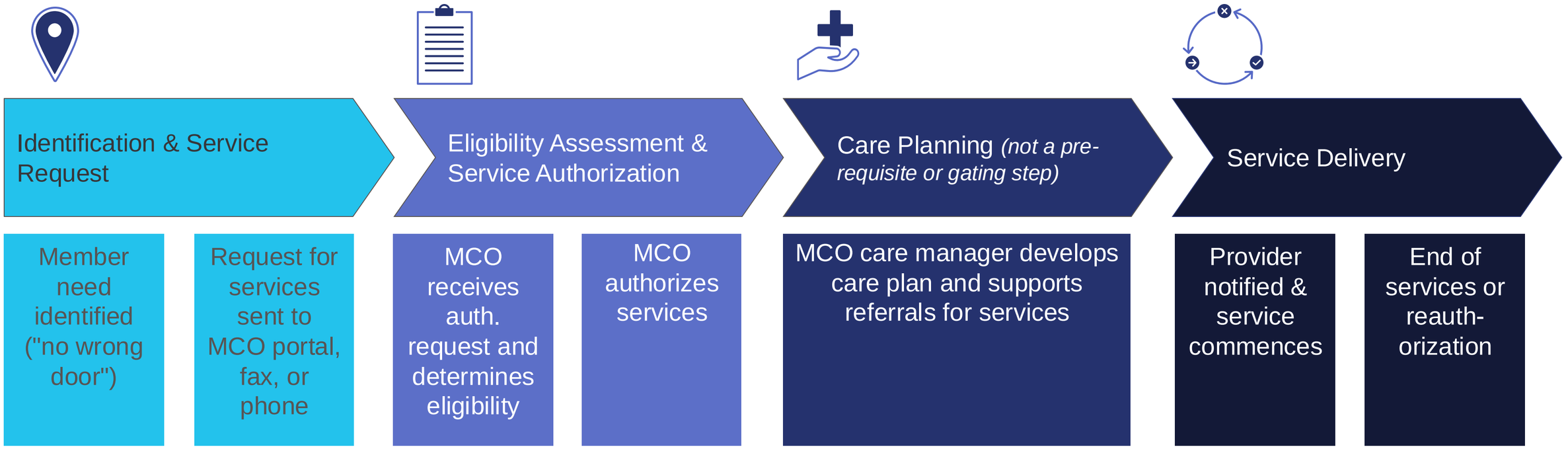
Housing Supports through 1115 waiver

- The Centers for Medicare and Medicaid Services (CMS) approved a renewal of New Jersey's 1115 Demonstration which includes innovative NJ FamilyCare projects designed to address priorities such as:
  - Addressing members’ housing-related needs
  - Integrating behavioral and health services
  - Providing new and creative approaches to care
- The renewal extends federal authority for NJ to operate large parts of the NJ FamilyCare program
- The renewal is effective from April 1, 2023 through June 30, 2028

Overview of Housing Supports program

Goals	• Help **find & maintain housing** for housing insecure members to **improve health outcomes** • Drive greater connection of the housing and health care ecosystems
Authority	• 1115 demonstration approved by CMS through June 2028
Geography	• Statewide
Services	• **Pre-tenancy services**: case management supports to help member find housing • **Tenancy sustaining services**: case management supports to help members maintain housing • **Residential modification and remediation**: modifications or repairs to home to ensure health & safety • **Move-in supports**: payment to support the setup of new housing or a move • Does not include payment for rent or housing production
Eligibility	• MCO enrolled • At least 1 clinical risk factor (e.g., chronic health condition, mental health condition) • At least 1 social risk factor (e.g., homeless, at risk of homelessness)
Provider qualifications	• Pre-tenancy and tenancy sustaining services: organizations with experience serving housing insecure populations; can demonstrate experience via participation in other comparable government programs • Modification and remediation services: licensed home contractors will deliver • Move-in supports: housing supports providers or MCOs can pay directly and be reimbursed for these costs
Admin model	• MCOs responsible for building network, paying claims, authorizing services, and MCO care management • Housing supports providers responsible for delivering services

Housing Support services pathway



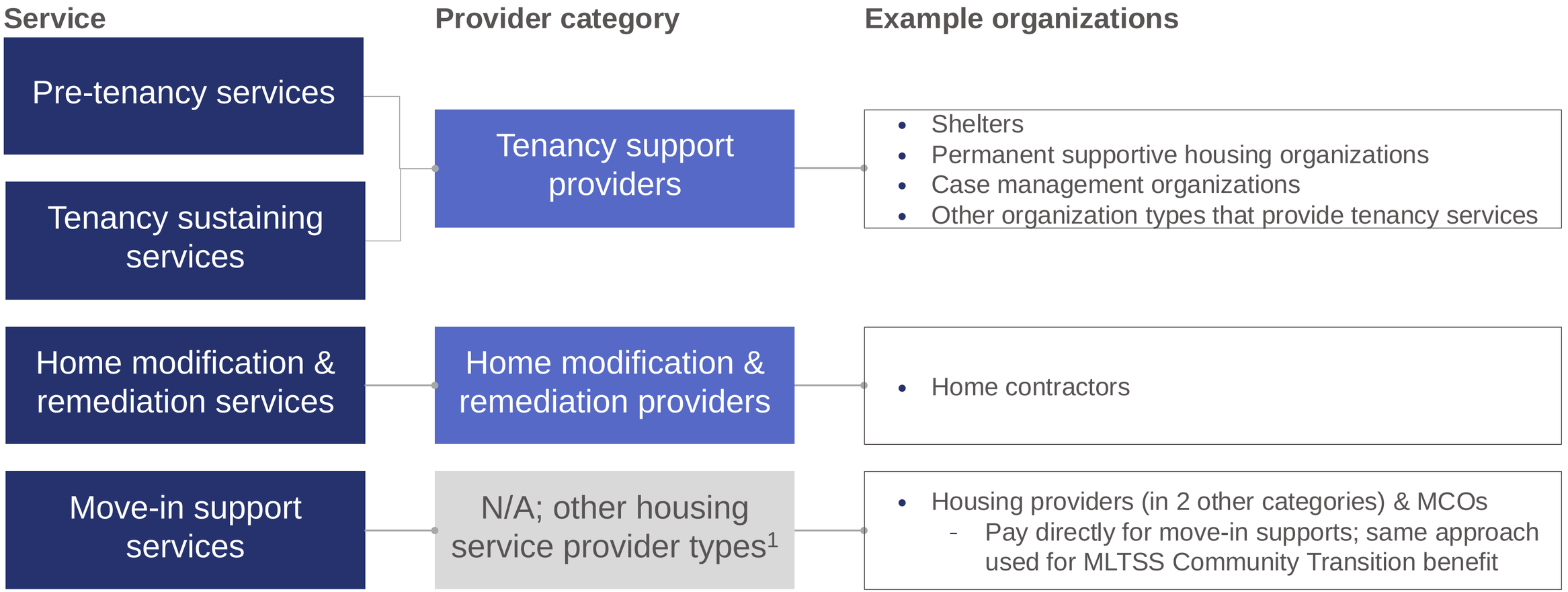
Program includes 4 broadly defined services

Pending CMS approval

Abbreviated

Pre-Tenancy Services	Tenancy Sustaining Services	Move-in Supports	Modification and Remediation
• Develop an individualized housing support plan to help member achieve their goals • Assist with the housing search and application process • Provide connections to resources aiding with housing costs and other expenses	• Develop an individualized housing support plan to help member achieve their goals • Assist with lease renewals and housing certification process • Connect the member to financial resources and social services, including linking members to education, employment and legal services • Assist in addressing circumstances and/or behaviors that may jeopardize housing • Assist in resolving disputes with landlords	• Pay for the set-up of the new housing unit, to address needs identified in the person-centered care plan • Pay for the move and supporting the details of the move	• Provide remediation services, including air filtration devices, asthma remediation • Modify home environment (e.g., ramps, handrails, grab bars) • Provide medically necessary heating and cooling services

2 housing provider categories based on the 4 housing services



1. Note: move-in supports includes paying for security deposits and moving costs. Tenancy support providers, home modification & remediation providers, and MCOs are well-positioned to directly pay for these kinds of wide-ranging costs. This approach means DMAHS doesn't need to enroll another kind of provider type to stand-up the program

Eligible members must be enrolled in an MCO, and meet at least 1 social and clinical risk criteria

Pending CMS approval

Abbreviated

Covered populations	+	Social risk criteria	+	Clinical risk criteria
MCO population (only)		At risk of homelessness or currently experiencing homelessness		Chronic health condition
		At risk of institutionalization and requiring a new housing arrangement		Mental health condition
		Transitioning from an institution to the community		Substance misuse
		Recently released from correctional facilities		Pregnancy
				Complex mental health condition from intellectual or developmental disability
				Victims of intimate partner violence, domestic violence, and/or human trafficking
				Assistance with activities of daily living (ADLs) or instrumental activities of daily living (IADLs)
				Repeated emergency department use or hospital admissions

4 steps to become a Housing Supports program provider

Conduct self assessment

Determine if your organization meets admin and financial capabilities necessary to run program services

- Is your organization capable of contracting with MCOs, standing up new billing, data reporting, and training staff?

Apply for National Provider Identifier (NPI)[1]

- A National Provider Identifier (NPI) is a privacy protected 10-digit number assigned to every health care provider in the United States
- Organizations can apply for NPIs through the Center for Medicare and Medicaid Services' (CMS') National Plan and Provider Enumeration System (NPPES)

Enroll with Division of Medical Assistance & Health Services (DMAHS)

- Apply to Medicaid enrollment via NJMMIS.com using 21st Century Cures Act application
- Regional health hubs will support application process and questions

Credential & contract with managed care organizations (MCOs)

- Complete standardized credentialing application to join managed care organization's provider network
- Each managed care organization has their own contracting processes and procedures
- Regional health hubs will support application process and questions

More guidance on enrollment & credentialing forthcoming

1. Organizations only need an NPI - individual staff do not need an NPI

NEW JERSEY HUMAN SERVICES

2 complementary DMAHS investments to build provider readiness

Provider readiness grants

Grants to housing organizations to incentivize provider readiness and cover startup costs

Housing organizations will **complete "milestones" demonstrating** key steps towards provider readiness (e.g., apply for NPI, contract & credential with MCOs)

DMAHS / DCA partnership

Training and troubleshooting supports

Supports offered to housing organizations to help **build provider readiness** and successfully deliver Medicaid housing supports services, including trainings and hands-on troubleshooting supports

Goal timing: start delivering trainings by Fall

DMAHS / Regional Health Hubs partnership

Provider Readiness Grants and Letters of Intent

Overview

DMAHS and DCA are partnering to distribute Provider Readiness grants to eligible housing organizations to incentivize provider readiness and cover startup costs

To be considered, housing organizations will be asked, among other requirements, **to prove engagement with 1+ MCO through an LOI**

Please email the below contacts to begin the process of obtaining and signing an LOI with an MCO

Aetna:
Joel Martinez at Martinezj15@aetna.com

Fidelis:
Marlene Mercado at Marlene.g.mercado@fideliscarenj.com

Horizon:
Alana McDonald at Alana_Mcdonald@horizonblue.com

United:
The Ancillary Community Support Services (ACSS) Network at hcbsprovidernetwork@uhc.com and Hilary Delany at hilary_delany@uhc.com

Wellpoint:
Rhonnda Talton at rhonnda.talton@wellpoint.com

Share contact information through interest survey

Fill out Housing Supports Services Program survey to continue receiving program updates and/or share contact info with MCOs

Scan the QR code or access the survey through the link below
https://www.113.vovici.net/se/13B2588B01099C2B

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Regional Health Hubs

Regional Health Hubs bring together multiple sectors to address state priorities and other pressing health concerns.

Functions of a Regional Health Hub:

- Convene stakeholders in healthcare and beyond around state Medicaid priorities.
- Operate a Health Information Exchange (HIE).
- Serve Medicaid and other state departments as a local expert, strategic planning partner and program implementer.
- Innovate on population and clinical health interventions in response to local needs.

HCPC Health Coalition of Passaic County

GNHCC Greater Newark Health Care Coalition

TrentonHealthTeam

Camden Coalition

The RHHs will help to facilitate providers' successful integration into the Medicaid system

RHHs will perform some of the following roles, throughout the state

- Deliver and curate trainings about the program
- Serve as a "help line" for providers to field/answer questions and troubleshoot issues throughout the process
- Liaise between the State, MCOs and providers to support implementation
- Promote the program to recruit a robust network of providers within their regions
- Conduct member/community engagement to inform program design

Next steps

- Email: Tristan.Gibson@dhs.nj.gov with any further questions or comments.

- Join upcoming meetings:
  - Next stakeholder meeting
  - Session announcing provider readiness grants
  - RHH trainings

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Michelle Griffith
Chairperson, Ocean County Advisory Board;
Community Consultant, DCA Advisory Board

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HOUSING ASSOCIATES

The Partnership Between Medicaid & Housing Services

Questions?

Thank you for attending the panel!

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Thank you to our Speakers!

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