Housing, Homelessness & Managed Care

Reinventing Quality Conference 2016

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National Context

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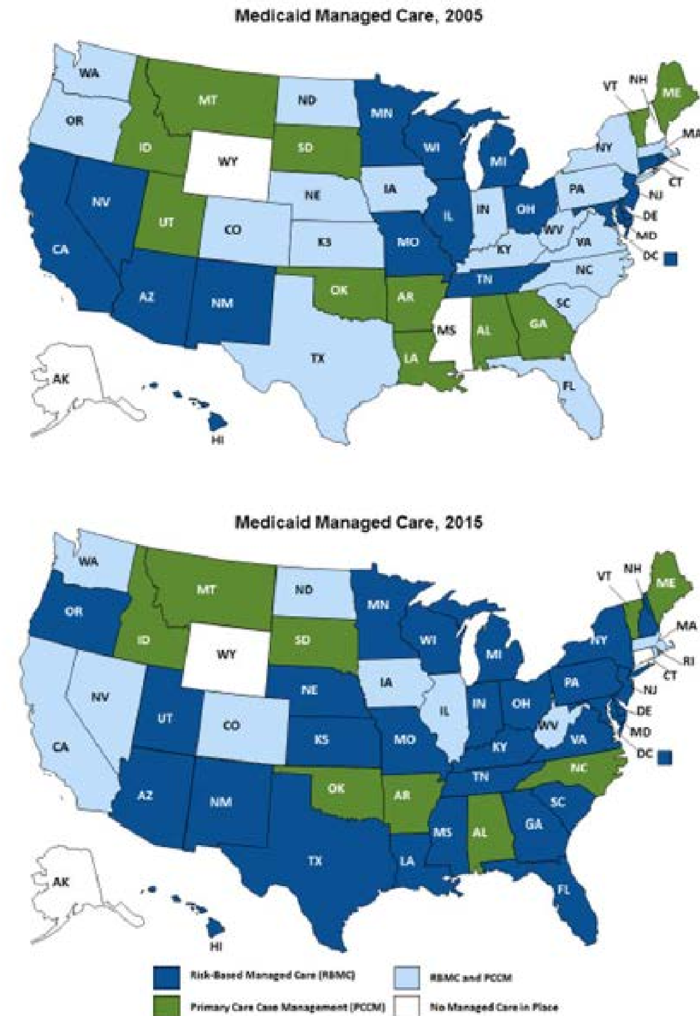
- Medicaid Expansion
- Growing Footprint of Medicaid Managed Care
- Greater Recognition of Social Determinants of Health



Source: HMA Value of Medicaid Managed Care

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Medicaid Managed Care

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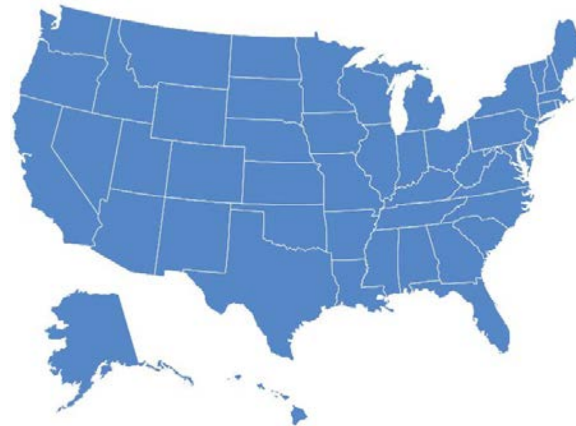
Source: Architect of the Capitol



Federal Government

- Establishes basic rules and criteria States must follow in the design and operation of a Medicaid program
- Covers a significant portion of the costs of Medicaid (varies by state and population)
- Approves contracts and rates between states and managed care entities

State Governments

- Establish program rules, benefits, eligibility, contract provisions and the rates health plans will be paid to administer the Medicaid program
- Compensates the health plans using a per member per month capitated rate

Health Plans

- Administer the Medicaid program according to the terms of the contract with the state for their assigned Medicaid beneficiaries
- Measured on ability to support their members in receiving preventive treatment, achieving state goals, and meeting other quality metrics established by the state
- Established contracts with providers

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Policy Considerations

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Medicaid benefit and program design shapes the opportunity!

- Expansion vs. non-expansion
- Populations under managed care contract
- Benefits under managed care contract – behavioral health, LTSS/HCBS, housing supports, etc.
- Medical Loss Ratio calculations
- Care coordination requirements
- State program priorities
- Delivery and payment reform requirements
- Quality definitions, calculations and accountability

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Texas Homeless Services Pilot

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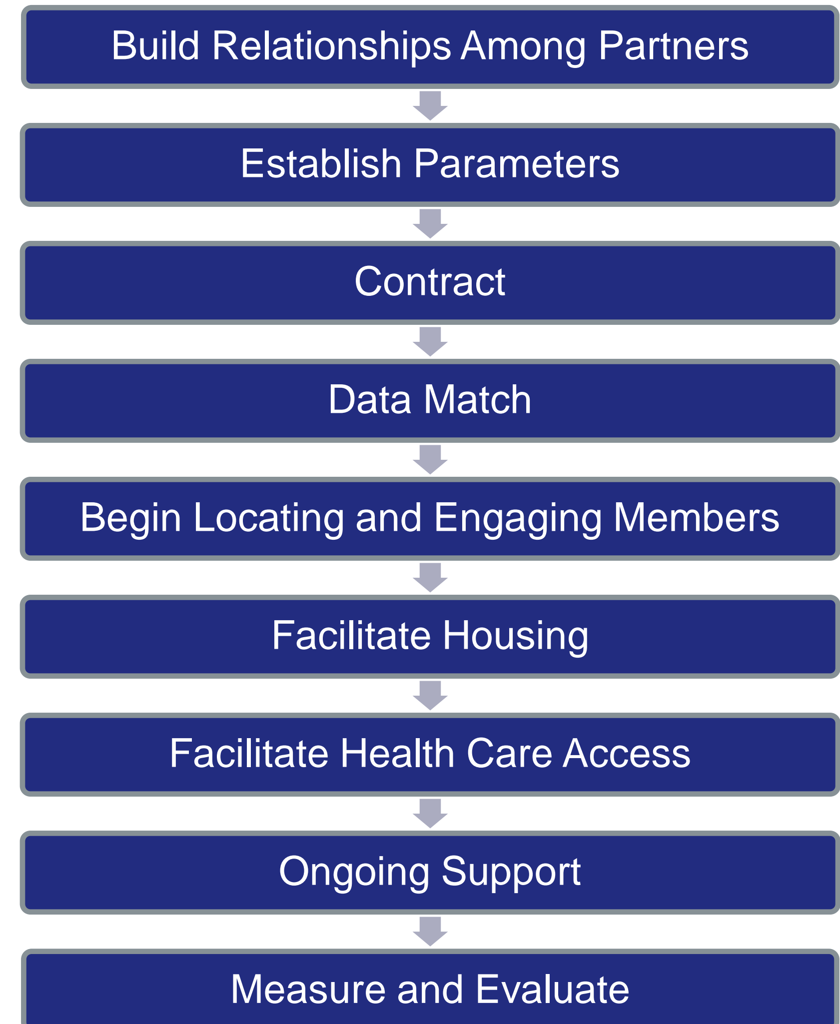
The Vision

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.



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Texas Pilot: Early Findings

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UnitedHealthcare	Community Partner (ECHO)
• Significant number of our members accessing homeless and housing services • Members accessing these services had an undesirable utilization pattern - limited to no preventative care or outpatient professional services and using hospitals and ERs • Across two counties, key target group was around 50 people with average of 4 hospital admits, 10 potentially preventable ER visits and presence of catastrophic diagnosis, diabetes and mental health	• We matched 281 client records and then found 146 who had already completed our new Coordinated Assessment • 49 had scored for PSH • 67 had score for RRH • These scores correspond with poor health, unmanaged disease, lack of support systems to provide care • Usual challenges: incarceration, come and go from services

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Healthcare for the Homeless Recommended Actionable Steps

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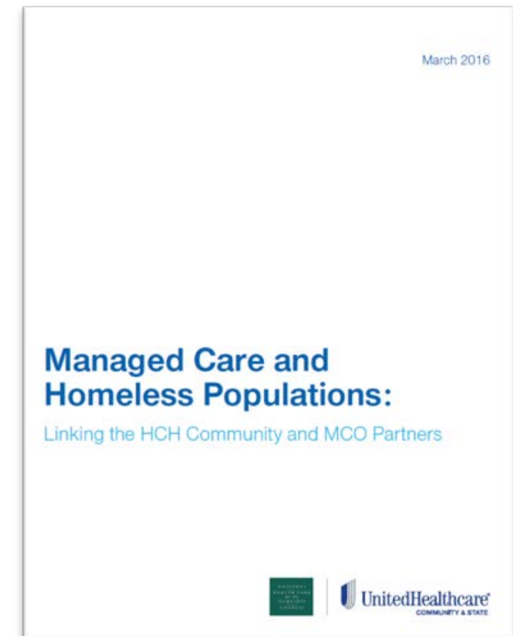
- Meet with MCOs and Identify Priorities
  - How do services align?
  - Is your organization ready to partner?
  - How does a partnership align with the state needs?
- Leverage Data
  - Leverage ICD-10 codes – work collaboratively to increase awareness of need to code
  - Find individuals both entities are serving – e.g. HMIS
  - Collect health insurance information
- Identify Challenges of Improving Health
  - Understand the system better – collectively
  - Customer authorizations
- Implement Smaller Tangible Pilots
  - State policy often take a long time to change
  - Use data from pilots to advocate for change over time
- Collaborate to Improve the Broader System
  - Educate on policy changes that foster natural collaborations across health and housing



Edited from our work with Healthcare for the Homeless

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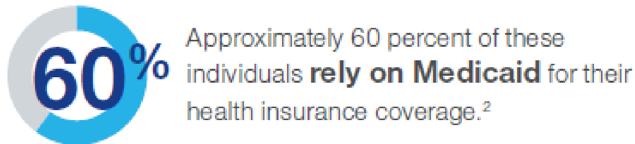
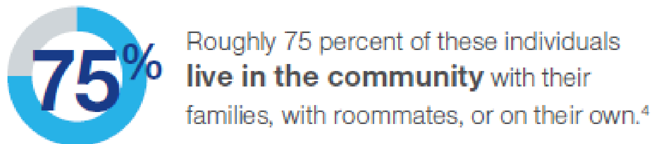
Alignment with ID/DD Community

There are nearly 5 million individuals in the US with ID/DD.[1]



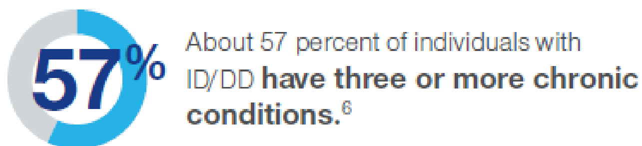
Approximately 60 percent of these individuals **rely on Medicaid** for their health insurance coverage.[2]

Almost **35,000 individuals** with ID/DD are in Medicaid managed care.[3]



Roughly 75 percent of these individuals **live in the community** with their families, with roommates, or on their own.[4]

Approximately **640,000 adults over the age of 60** have ID/DD and this number is expected to exceed **1.2 million adults in 30 years.** However, the majority of individuals with ID/DD are under the age of 60.[5] It is important to note that many older adults have intellectual disabilities but **do not have developmental disabilities** due to brain injury, Alzheimer's or stroke acquired post age 22.



About 57 percent of individuals with ID/DD **have three or more chronic conditions.**[6]

May 2016

Quality Improvement for Individuals With Intellectual & Developmental Disabilities

A Proposed Framework

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Questions?

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