Homelessness and Urban Sustainability: How will the assistance needed by homeless people be financed?

Karen Batia, Ph.D.

A National Academies Workshop

November 12, 2014

Recommendations

- Risk stratification methodology for different homeless populations
- Capitation based on true and comprehensive costs to care for each population
- Base incentive payments (shared savings, risk-based arrangements) on progressive outcome goals appropriate for vulnerable populations – ultimate goal to achieve same outcomes as a commercial based population

Recommendations

- Encourage states to develop “housing support friendly” Medicaid taxonomies that include habiltative interventions
- Create mechanisms that help match the right level of housing supports to the populations that need that level of support
- Recognize that “permanent housing” must incorporate a continuum of housing supports that fit the needs of a population and needs that change over time

Recommendations

- Encourage states to blend or braid Medicaid funding with grant funds that can impact the social determinants of health
- MCO contracts with states must incentivize
  - incorporation of housing supports
  - differing care coordination models matched to population needs
  - standards of care for homeless populations

Impact of managed care on homeless populations

Opportunities

- Potential to pay for needed services not currently covered in traditional Medicaid taxonomies
- Potential to incorporate services that impact social determinants of health
- Potential to develop creative service solutions specifically targeted to needs of specific homeless populations (i.e. outreach, Integrated ACT)

Impact of managed care on homeless populations

Challenges

- Claims data determines risk stratification typically
- Traditional care coordination models not sufficient
- Significant education and outreach needed to match plans to needs of the population
- Significant churn leading to disruptions in continuity of care
- Impact on specialty homeless providers

Together4Health ~ A Care Coordination Entity (Chicago)

- A collaboration of providers that created and implemented a Care Coordination model – an integrated delivery system; risk-based payment based on health outcomes
- Includes participation from hospitals, primary care providers, and behavioral health providers (34 owner organizations now incudes over 100 contracted provider organizations)
- Provider-led network → full risk health plan??

Together4Health ~ Goals

- Ensure that our participants experience the highest quality care
- Improve the health of vulnerable populations (high utilizers of Medicaid)
- Reduce the per capita cost of health care
- Reduce health disparities
- Share accountability for the outcomes of patient care across the partnership
- Address social determinants (lack of housing, employment, food security, and social supports) that have a negative impact on health
- Continue to revise and improve the model, according to input from research partners who evaluate and report on network services, outcomes and disseminate findings

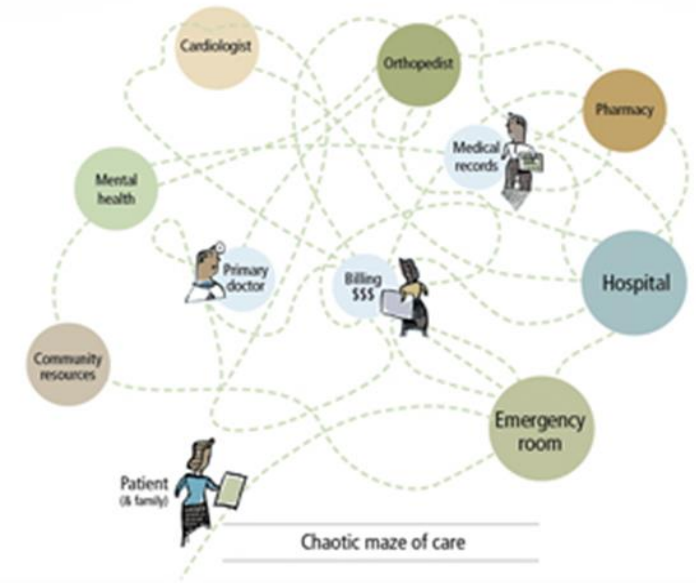
Together4Health ~ Financial Model

- Shared risk, shared revenue opportunity
- Owner capital investment
- Per member per month care coordination fee
- Initial three years providers directly paid FFS; business as usual
- Shared savings based on Medicaid savings and achieving health outcomes in comparison to MCO performance
- Full risk after 3 years???

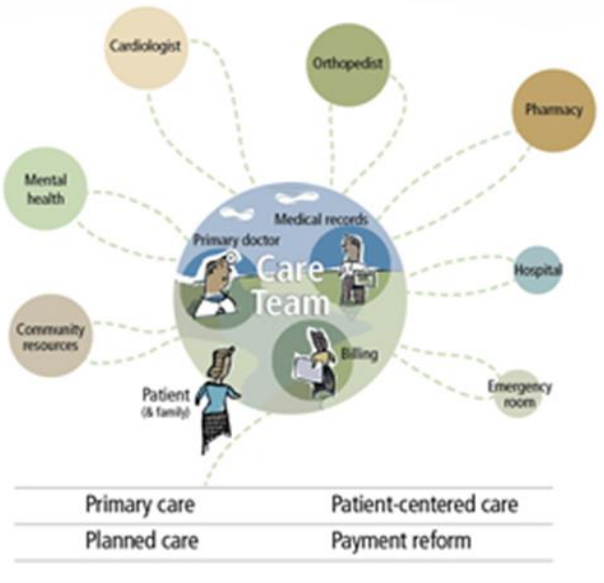
T4H Serves ~

- High Medicaid (SPD) users – new to network and receiving services from T4H network providers
- Year one over 1700 → goal of 5000 by year three
- 100% people served will have a disability
- Majority of people served have multiple chronic health illnesses with and without serious mental illness (SMI)
- Enrollment auto assignment and voluntary enrollment

Today



Tomorrow



T4H clinical care model

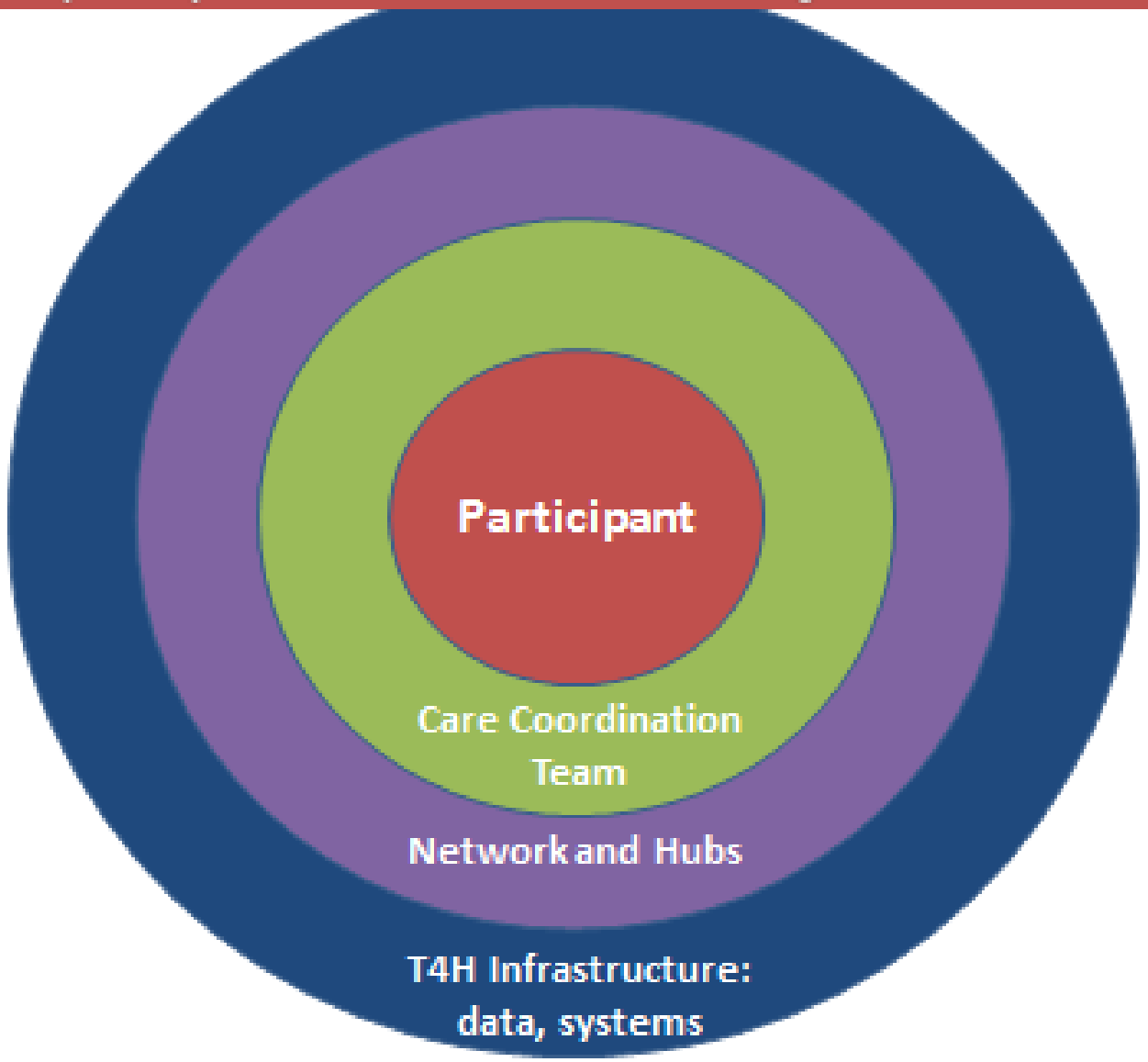
- Illinois issues
  - Illinois' hospital readmissions rates for Medicaid patients among the worst in the nation: 45% of Medicaid spending in Illinois on inpatient hospital procedures compared to national average of 25%

- How do we fix a broken system?
  - Brought together our community partners and asked them what was missing
    - **Data**
    - **Communication**
    - **Resources**
    - **Outreach**

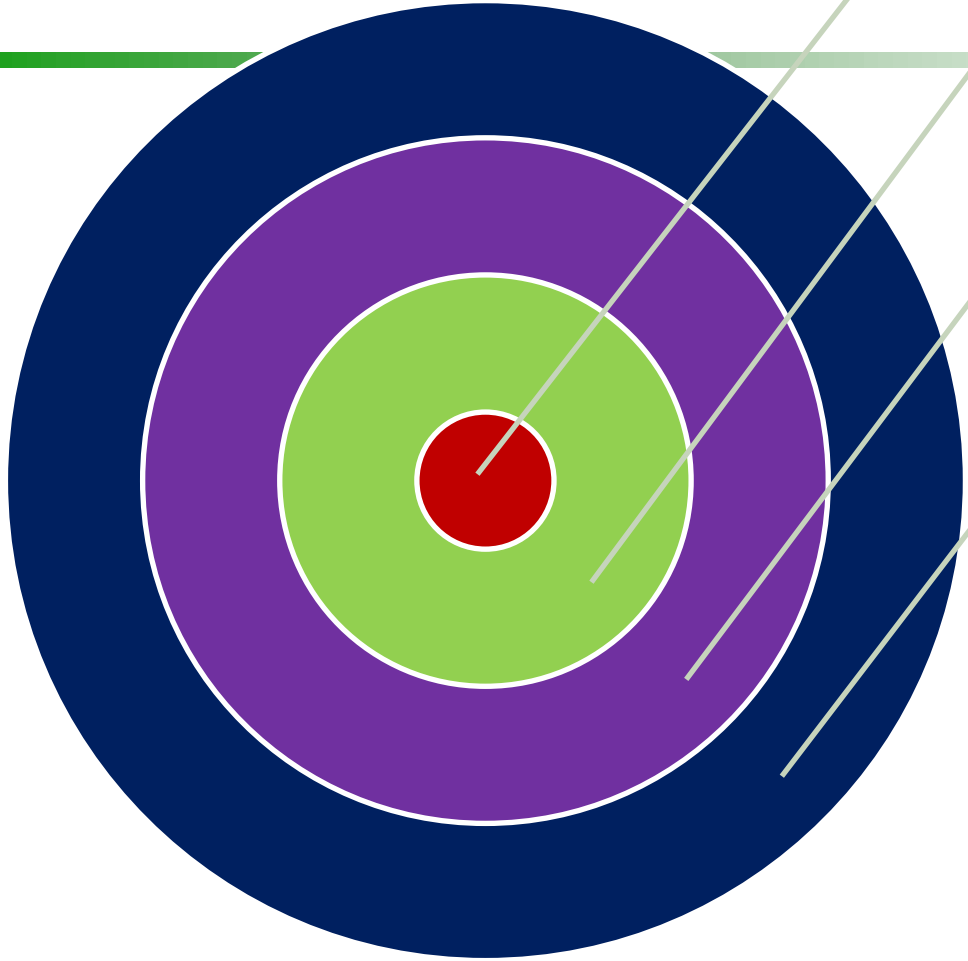
T4H clinical care model

- Based on health home option
- Whole person: Integrates holistic approach that promotes physical, mental, and social wellbeing, while improving access to care
- Addresses the social determinants of health, such as housing
- Canvassing Chicago land through Health Home hubs (neighborhoods)

How a Participant Experiences Care Coordination in Together4Health



T4H Layers of Care Coordination



Participant

- Activation
- Social Determinants of Health

Care Coordination Team

- Care Coordination Assessment
- Manager of Care Coordination Care Plan
- Participant Activation in Self-Management
- Linkage to Services

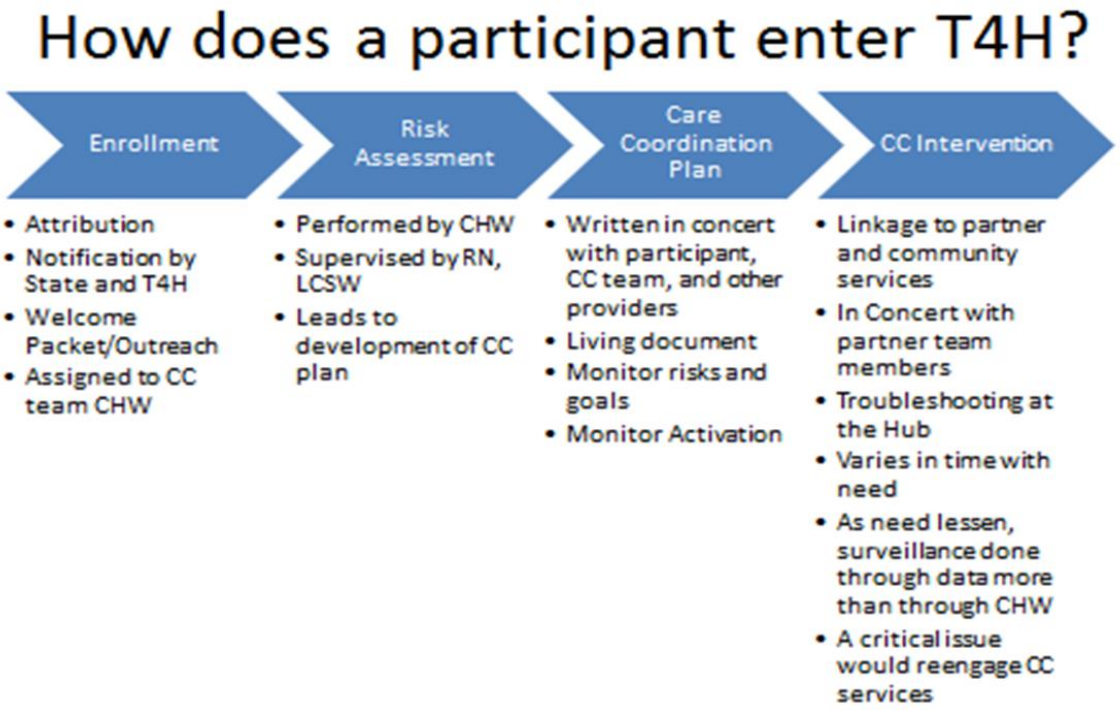
Network and Hub

- Richness of T4H Network service providers
- Strong relationship amongst providers
- Troubleshooting of individual participant needs
- Innovation in Network

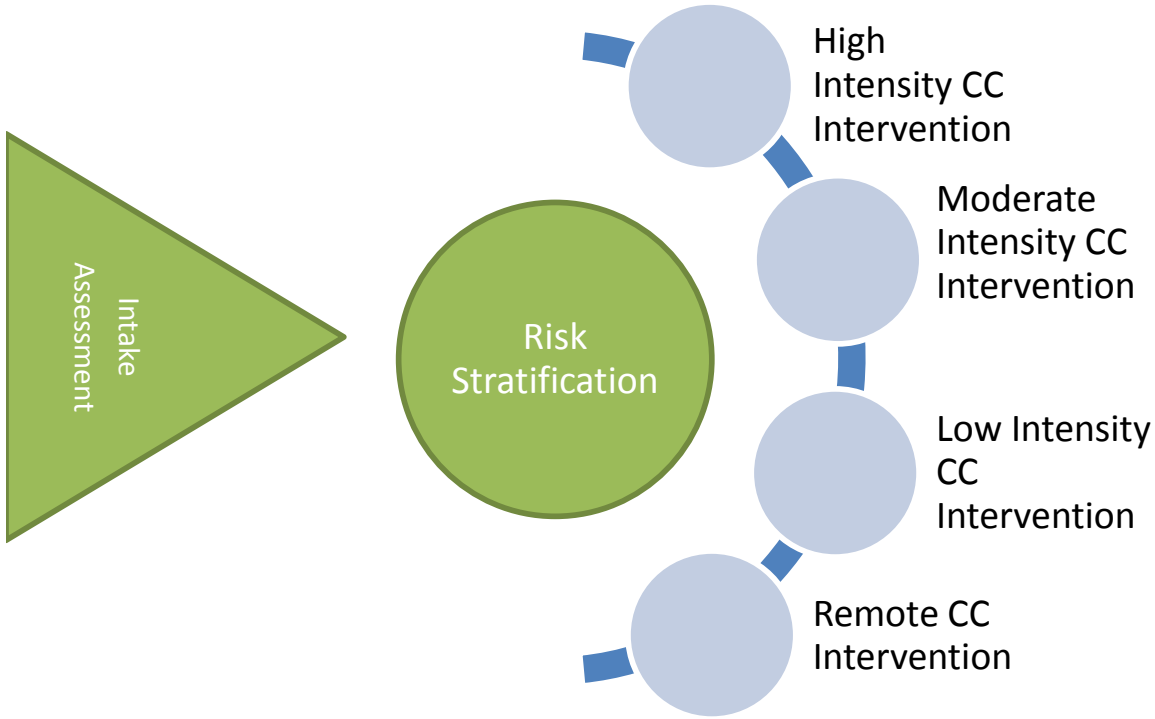
T4H Infrastructure

- Shared data
- Universal Consent
- Training
- Quality Improvement
- Advocacy

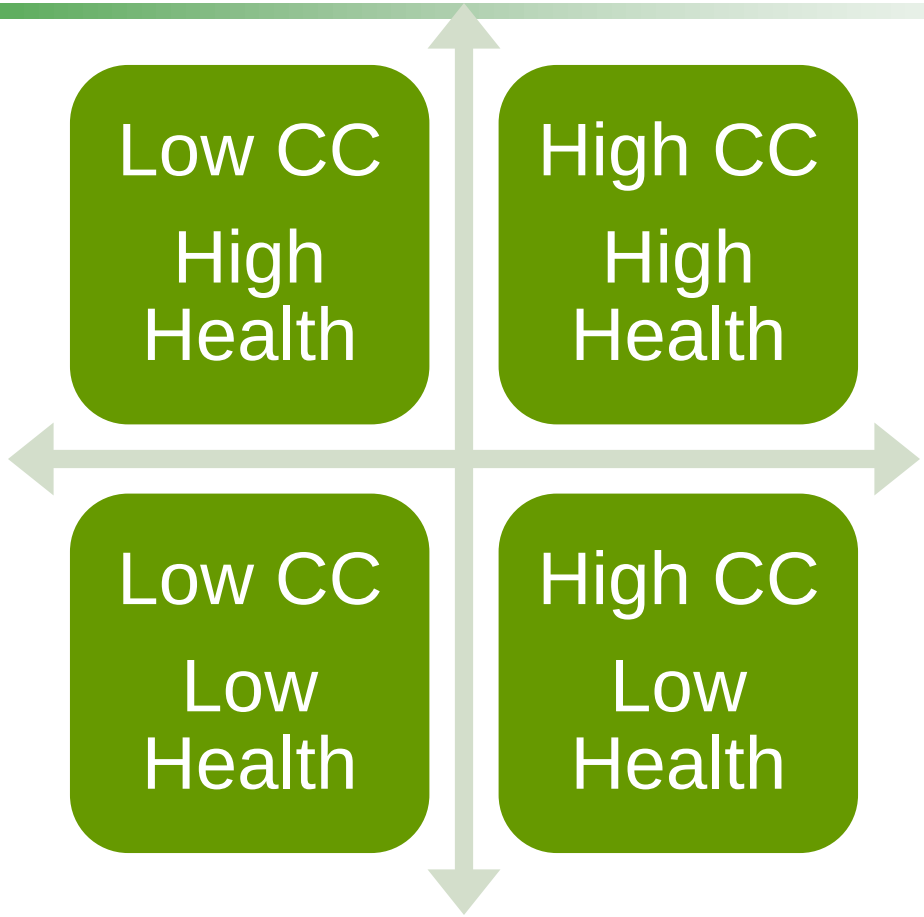
Engagement and Assessment



Risk Stratification



Care coordination needs



Risk Stratification

- Insignia Patient Activation Measurement Tool
  - Simple, broad (applies to any health issue/disease)
  - Evidenced-based with outcomes and decrease cost
  - In line with HCH and community partners philosophy

Care Coordination Intervention

- Directed, short term intervention
- Activating
- Connect to resources
- Be available
- Reenter with red light event

Lessons learned

- Enrollment
- Confusion with a new system
  - Participants
  - State
  - Service providers
- Reevaluation of model presumptions
- Building the data infrastructure – claims data, care coordination information, enrollment files, pertinent health information

Challenges

- Chaotic and confusing healthcare landscape
  - 20+ managed care options for Medicaid recipients
  - Provider organizations need to contract with multiple entities
- IL continues to make changes that impact daily operations and needed infrastructure
- CCEs not understood and at competitive disadvantage as compared to MCOs
- Network growth – both opportunity and challenge
- Limited infrastructure and capital

Future

- T4H must figure out how to get funds to provider partners especially non Medicaid providers
- MCCN preparation within FFS system
- Medicaid payments for nontraditional services such as housing supports?
- Building consensus regarding how to use capitated funds
- Business development with MCOs and other payers