Attachment A: **TEMPLATE FOR TRANSFORMATION PROJECT SUGGESTIONS**

Completed by **January 15, 2016,** email to MedicaidTransformation@hca.wa.gov w/subject **Medicaid Waiver Project**.

Contact	*Point person, telephone number, e-mail address* Mark Putnam, All Home Executive Director 206-263-9001, mark.putnam@allhomekc.org *Organizations involved in developing this project suggestion* *All Home (Seattle / King County's Homelessness Continuum of Care); King County Dept. of Community & Human Services, King County Public Health/Healthcare for the Homeless, Seattle Office of Housing*
Project Title	*Title of the project/intervention:* King County Supportive Housing Access and Alignment Committee

Rationale for the Project

Problem statement – project need; supporting research; relationship to federal Medicaid objectives; benefit to Medicaid beneficiaries.

The National Health Care for the Homeless Council states, "homelessness creates new health problems and exacerbates existing ones." Ample evidence exists that supportive housing improves health outcomes and reduces health care and other system costs for people who are chronically homeless.

This project suggestion is submitted under Initiative 1's "Health System Capacity Building" domain. Under Medicaid expansion, the King County region has enrolled significant numbers of previously ineligible adults into the Medicaid program. A subset of these is homeless, and characterized by complex chronic physical and behavioral health needs. Our region faces a significant lack of supply for safe, stable, affordable housing with appropriate support services for these Medicaid beneficiaries. This creates a need and opportunity for deeper partnerships between Medicaid providers and payers with our region's homeless and housing programs.

The project will address a growing need for system-level coordination of existing and new supportive housing in the King County region, including technical assistance (TA) to local Permanent Supportive Housing (PSH) providers in order to maximize the use and impact of the new PSH Medicaid benefit proposed under Initiative 3 of the Medicaid Transformation Waiver. This TA will bring together housers, health care providers, Managed Care Organizations (MCOs), local government and funders, among others. These partnering agencies and systems will seek to assure that as a community we are leveraging other resources, aligning strategies and working together to better understand and implement the PSH benefit. The intent is to work in partnership with the Health Care Authority to reduce risk for people with chronic medical and/or behavioral health conditions who have exited homelessness into PSH, in the context of achieving the triple aim of better health, better care, and lower health costs for the population. This initiative will ultimately set the stage to expand housing opportunities for homeless individuals with complex health and behavioral healthcare needs in the Seattle/King County Continuum of Care (CoC).

This project aligns with the federal objective for Medicaid as it will:

- Use innovative service delivery systems that improve care, increase efficiency, and reduce costs; and
- Provide technical assistance to PSH providers, allowing them to expand eligibility, leverage community resources and improve access to housing among individuals experiencing homelessness

Project Description

Which Medicaid Transformation Goals[i] are supported by this project/intervention? Check box(es)

- ☑ Reduce avoidable use of intensive services
- ☑ Improve population health, focused on prevention
- ☑ Accelerate transition to value-based payment
- ☑ Ensure Medicaid per-capita growth is below national trends

Which Transformation Project Domain(s) are involved? Check box(es)

- ☑ Health Systems Capacity Building
- ☑ Care Delivery Redesign
- ☐ Population Health Improvement – prevention activities

Describe: Region(s) and sub-population(s) impacted by project and target population

People experiencing homelessness are characterized by complex and often chronic physical and behavioral health conditions. Many are involved in the justice system, and many are frequently hospitalized and/or are frequent emergency department users in King County. Entry into PSH provides a measure of stability that housers and their health care partners can leverage as a platform for better disease management, patient activation and support for health behavior changes, and improved use of regular preventive care.

The January 2015 One Night Count (ONC) identified at least 10,047 people experiencing homelessness in King County, with 815 chronically homeless. The ONC also identified sheltered individuals with known disabilities and selected

health conditions by program type. See Table 6, from the 2015 King County One Night Count:

	Overnight Shelter	Transitional Housing	Combined Total*
Mental Illness	529	539	1,068
(Subset with serious mental illness)	(344)	(251)	(595)
Alcohol or Substance Abuse	434	445	879
(Sub set with chronic SA)	(242)	(178)	(420)
Physical Disability	330	359	689

**Survey methods do not ask unsheltered individuals about disability status, mental health or substance abuse.*

Relationship to Washington's Medicaid Transformation goals.

This project will positively affect each of Washington's Medicaid Transformation goals, particularly:

- Reducing avoidable use of intensive services and settings among high service needs individuals;
- Improve the health of homeless individuals through a coordinated, person- centered approach; and
- Accelerate the transition to value-based payment.

Project goals, interventions, expected outcomes; including improving health equity/reducing health disparities.

Goals & Outcome: Reduced Medicaid spending per enrollee. The Medicaid waiver is likely to spur many strategies whose health outcome goals relate to improving beneficiary access to housing and case management related to housing. Per the Corporation for Supportive Housing, the top five percent of Medicaid beneficiaries in King county who identified as homeless had average monthly Medicaid expenditures of $3,704. If housed, CSH projects annual savings of = $957 per enrollee per year.

Intervention: Technical Assistance to Seattle/King County CoC partners and system coordination activities that would include health system partners (such as hospitals, federally qualified health centers, behavioral health agencies, long-term services and supports, and managed care plans), in order to effectively utilize the PSH benefit and coordinate care for PSH residents.

Reducing Disparities: Individuals who are homeless (who are disproportionately people of color), experience health problems, especially chronic illnesses, with greater prevalence than those who are housed, and they suffer mortality rates three to four times higher than those in the general. By increasing capacity to utilize the PSH benefit, partners will be better placed to house and support this vulnerable cohort in a way that reduces the risk for hospitalization and poor health outcomes.

Links to complementary transformation initiatives.

- Washington State's plan to fully integrate care for mental health, substance use and physical health by 2020 via Early Adopter of Fully Integrated Managed Care; supporting efforts to integrate at the delivery-level. Supported through legislation and State Innovation Model Test.
- UW Integrated Care Psychiatry Training Program (UWICPTP), supported by Washington's 2015-2017 biennial budget, to train psychiatrists and other health care providers in proven, population-based integrated behavioral healthcare, including collaborative care.
- Improved outcomes for LTSS beneficiaries, as mental health conditions are very common in Medicare-Medicaid eligible, with 41% having one or more mental health diagnoses.
- King County's Health & Human Service Transformation plan – Investing in What Works. By 2020, King County residents will experience significant gains in health and well-being through a shift from a costly, crisis-oriented response to health and social problems, to one that focuses on prevention, embraces recovery, and eliminates disparities. Recognizing that: 1) Prevention is the most effective, least expensive way to avoid costly negative outcomes such as chronic disease, domestic violence, mental illness, and homelessness; 2) Embracing innovative strategies and partnerships like The Seattle Foundation grants that allow communities to take a leadership role and address the specific needs of neighborhoods; and 3) Using data-informed approaches to ensure we are using the best evidence to get better outcomes.

Potential partners, systems, and organizations (e.g., health and social service providers, ACH participants).

Proposed partners include but would not be limited to: All Home; King County Department of Community and Human Services (which serves as the Behavioral Health Organization); Public Health-Seattle & King County's Health Care for the Homeless Network; Seattle / King County's Continuum of Care PSH Providers; the Area Agency on Aging, and health system partners such as hospitals, FQHCs, and managed care organizations. Given that health/housing partnerships are a stated initial priority of the King County Accountable Community of Health, we would seek to engage with the ACH to establish connections to its governance body to assure that these efforts are connected with larger health system transformation activities in the region.

Core Investment Components

Proposed activities and cost estimates ("order of magnitude") for the project.

Technical Assistance activities include

1. Working to align capital and service funding,
2. Developing a 'home base' for ongoing discussions to improve system coordination and link PSH benefit-related work to work on federal mandates, such as HUD requirements for Coordinated Entry),
3. Data analysis, and
4. Fostering connections between housers, health care providers, and Medicaid MCOs.

A system coordination committee will be co-convened by All Home; Public Health Seattle & King County's Healthcare for the Homeless Network and King County's Behavioral Health and Recovery Division. It will build on the state-level work of the Chronic Homeless Policy Academy and link the work to the ACH as an element of housing-health partnership. Cost estimate: $160,000 per year to support one FTE system coordinator, hosted with King County.

Best estimate (or ballpark) for number people expected to serve, on a monthly or annual basis

N/A - this TA proposal is intended to build system capacity, rather than provide direct services to individuals. (The numbers of Medicaid clients served through PSH will depend on the design and roll-out of Initiative 3.)

How much you expect the program to cost per person served, on a monthly or annual basis. **N/A –** not a per person proposal.

How long it will take to fully implement the project within a region where you expect it will have to be phased in.

Operational within four months, allowing time to hire staff, and convene system coordination committee.

The financial return on investment (ROI) opportunity, including estimated amounts and associated ROI timeline.

Insofar as the proposed technical assistance will support partners to effectively utilize the PSH benefit and coordinate care for PSH residents, cost criteria can be used to identify people who are frequent users of, or at risk of, becoming frequent users of public systems who need supportive housing. Washington State Research and Data Analysis Division's (RDA) 2012 analysis shows average annual per person health and behavioral health care Medicaid costs of $33,459 in SFY 2012 for 2,042 chronically homeless individuals in the top cost decile. Using data from RDA's study and a body of published empirical evidence, the Corporation for Supportive Housing estimated an average total Medicaid cost reduction of $6,360 per beneficiary per year (or $3,180 of the state's share of these costs). When accounting for the costs of providing supportive housing services, the net annual savings per beneficiary equals $957 ($479 state share). (Corporation for Supportive Housing. 2014. Creating a Medicaid Supportive Housing Services Benefit: A Framework for Washington and Other States.

Project Metrics

Defined outcomes that relate to the goals and specific process steps. Wherever possible describe:
Key process and outcome measures (and specific benchmark performance data if known). Include priority measures sets described in the Waiver application http://www.hca.wa.gov/hw/Documents/waiverappl.pdf *pages 46-47*

As described in the state's Medicaid Waiver application to CMS, the effect of providing a foundational community support such as supported housing is expected to drive improvements in health outcomes and reductions in health care costs for the subset of beneficiaries served. Based on previous studies of PSH, examples of measures from the Healthier Washington Common Measure Set for Health Care Quality and Cost that are likely to be impacted include: access to primary care, potentially avoidable ED visits, 30-day all cause readmission; and Medicaid spending per enrollee, among others.

Outcomes for this system coordination/TA project would be developed with project partners, with the primary outcome expected to be an increase in capacity of the housing system to prioritize and house high-need adult Medicaid beneficiaries as a result of being equipped to utilize the PSH benefit.

In addition, co-benefits will be realized outside the health care realm as a result of more adults accessing PSH in the region, such as improved housing stability, reductions in public crisis services, and reductions in justice system involvement.

If no specific benchmark performance data are currently available, what efforts will be undertaken to establish benchmark performance ahead of any proposed project implementation?

The system coordination committee established through this project looks forward to partnering with Healthier Washington on the overall evaluation of the permanent supportive housing benefit.