

MEDICAID WAIVER PROJECT PROPOSAL
METROPOLITAN DEVELOPMENT COUNCIL

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Project Title	Billing of Medicaid for Housing Stability Services
Rational for the Project	
<p>Many individuals with serious and complex behavioral health disorders who have been homeless for extended periods of time experience serious, chronic health issues. On average they die 25 years younger than the average population, from treatable and preventable conditions, yet they often do not get care outside the expensive, emergency system, which is ill-equipped to manage their care. Research is fairly clear that, for this population, integration primary and behavioral healthcare with housing achieves the best outcomes.</p> <p>Increasing evidence exists for the positive outcomes of integrating behavioral and medical/primary healthcare. In a meta-analytical study conducted by Woltmann, Grogan-Kaylor, Perron, Georges, Kilbourne, and Bauer (2012) comparative effectiveness of collaborative and integrated care models for individuals with mental illness, substance use disorders, and chronic health conditions, improvements were shown in both behavioral health and chronic health outcomes over decentralized service models. A similar study by Miller, Grogan-Kaylor, Perron, Kilbourne, Woltmann, and Bauer (2013), which reviewed 53 studies comparing integrated care to traditional models specific to depression found that there were significant improvements in depression reduction, mental quality of life and physical quality of life when employing an integrated model of care.</p> <p>While there is less research on integrating housing with primary and behavioral healthcare, the Corporation for Supportive Housing reports strong outcomes, particularly around improving tenants' health status and dramatically reducing their costly use of crisis and inpatient services (Integrated Healthcare & Supportive Housing- A Report on a PCDC/CSH Market Assessment & Convening, 2014). According to this report, "Despite positive outcomes from partnerships, integrated health/housing models remain on the periphery of health systems. Much of this can be attributed to difficulties in working out how to link and coordinate their respective resources."</p> <p>The Federal Medicaid objectives this supports are <i>Improve health outcomes for Medicaid and low-income populations</i> and <i>Increase and strengthen coverage of low income individuals.</i></p>	
Project Description	
<p>This project will incorporate primary healthcare and behavioral healthcare into housing, as well as move from generic case management to clinical case management under the supervision of an MHP. The healthcare services are billable under Medicaid currently, but the housing stability case management is not, nor is the care coordination. This project proposes the ability to bill Medicaid for</p>	

the housing stability services conducted by a Clinical Case Manager. The Clinical Case Manager will also be responsible for coordinating all care provided to the individuals, and tracking their use of emergency services as well as their use of scheduled medical appointments.

The goal will be to reduce the use of intensive services through **Care Delivery Redesign**.

The region covered will be Tacoma/Pierce County, and the target population will be individuals coming out of street homelessness into permanent supportive housing, who experience complex medical and behavioral health conditions. The relationship of this project to Washington's Medicaid Transformation waiver is the intended **reduction of avoidable use of intensive services and settings such as acute care hospitals, nursing facilities, psychiatric hospitals, traditional LTSS and jails**.

The goals of this project will be to improve housing stability (or provide housing if entering the project after it begins), improved health, and decreased costs to the larger health and criminal justice systems. The interventions used will be care coordination (via a Clinical Case Management model), with integrated primary and behavioral healthcare services- as well as services related to the social determinants of health.

Health equity will be improved due to serving the disparately represented populations living in poverty and experiencing homelessness. In Pierce County, for example, African Americans represent 7% of the population, yet they represent 35% of those experiencing homelessness. By focusing on this population, these disparities will be reduced over time. By providing educational and employment opportunities to this project (another core service of MDC), once stable, the opportunity to give back to one's community will increase.

Initially MDC proposes to pilot this integration on its own (MDC offers primary care, mental health, and substance use services, as well as housing, education and employment services. Partners will include those who make referrals to the program (Pierce County, the City of Tacoma, Greater Lakes Mental Healthcare, and Comprehensive Life Resources), and coordination of specialty medical care through the two large health systems in Pierce County (the Franciscan and MultiCare Health Systems). Currently MDC uses the same electronic medical records as these two systems, making it very easy to share information from specialists or any inpatient care.

Core Investment Components

The activities to be provided will include: Care Coordination with primary medical and behavioral health providers, as well as specialty providers and connections to wellness services such as exercise, nutrition, healthy whole foods, smoke cessation, etc.; Counseling about who to turn to with medical/behavioral health concerns- how to access non-emergency services after hours; development of a care plan that focuses on health and wellness recovery; Counseling about general life issues, and where to focus one's generativity; and, Counseling about how to be a good tenant and neighbor. These activities will be conducted by the Clinical Case Manager.

The proposed cost estimates (using the current mental health rate for community mental health, plus a premium add-on for providing the services where the clients are located) are \$140/60 minute intervention. For individuals in this project it is expected they will have more frequent contact earlier on, and then reduced contact over time. Using an estimated 60 clients for this project, the order of magnitude cost estimate would be approximately \$200,000/year. The expectation would be an

average of 2 interventions per month (more in the beginning and fewer as they stabilize), making the cost per person per year, approximately \$3,330 or \$278/month.

The amount of time to fully implement will be approximately 180 days, and the cost savings will likely be significant. Currently people who experience long-term homelessness with complex health and behavioral health needs cost the system approximately \$35,000/year on average. Given that the activities associated with scheduled wellness and healthcare will cost something, as will the Clinical Case Management, the reduction of cost is still likely to be around 70%. Therefore the savings per person per year would be around \$30,000, making the savings for the 60 individuals in the project approximately 1,500,000/year.

Project Metrics

Process measures will include: a holistic intake and Unified Wellness and Recovery Plan for each individual in the project; a Clinical Case Manager assigned to each individual in the project; a team assigned to work with each individual in the project; and, a Crisis Plan developed for each individual in the project (designed to provide an alternative to expensive emergency services when an individual feels a crisis coming on).

Outcome measure will include: reduced substance use; improved psychiatric symptoms; decrease use of emergency medical and criminal justice systems; increased housing stability; improved chronic health symptoms; improved financial stability; improved quality of life; and increased generativity.

MDC will work with the Washington Community Mental Health Council, the National Behavioral Health Council, the National Alliance to End Homelessness, the Corporation for Supportive Housing, and the Federal Substance Abuse and Mental Health Administration to identify the best benchmarks available for this population. Additionally, MDC will identify the data set necessary to measure the outcomes listed above.