



SIM COMMUNITY LINKAGES WORK GROUP MEETING # 2

Wednesday, December 16, 2015
1:00 pm – 2:30 pm

**DHCF 441 4th Street, NW; South
Old Chambers Room, 1st Floor**

Dial In: 877-414-4629; Participant: 5500291

AGENDA

- 1. Introductions and Meeting Purpose**
- 2. Presentation on the Medicaid Health Home benefit for Individuals with Chronic Physical Health Conditions, and Homeless Individuals (HH2)**

The presentation will address:

 - The Health Home model and DC's proposed HH2 benefit design?
 - Who will the HH2 benefit target
 - Collaboration between HH2 providers and Permanent Supportive Housing & Outreach Providers
- 3. Homework: HH2 Providers and PSH/Outreach Provider Communication**
- 4. Wrap Up and Next Steps**
 - We are not meeting in January, and instead would like this group to join the Care Delivery Workgroup's meeting on January 12th, where the discussion will focus on the HH2 and social services
 - The next Community Linkages meeting is scheduled for Wed, February 17th, where we will continue our discussion on data sharing and analysis:



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<p>1. Learning Collaborative Starting with information sharing that is focused on connecting consumers to services. Building on the information sharing to create a referral system, complete with protocols and procedures. Leveraging referral system into contractual relationships that can take advantage of the expertise of homeless service providers to realize cost savings for Medicaid plan providers.</p>	<p>SIM Community Linkages (contact Dena Hasan (DHCF), dena.hasan@dc.gov) Carleta Belton (DHCF) is point of Contact for MCO</p>	<p>Priority: High Timeline: Immediate & near term</p>	<p>Resources & Level of Effort:</p> <ul style="list-style-type: none"> Both MCOs and homeless services/supportive housing providers expressed interest in learning more and developing concrete relationships Potential to leverage partners (e.g. Behavioral Health Association, DCFPI, etc) Opportunity to use PSHP provider mtgs or Medicaid WG as forum Learning collaborative identified as a task that likely requires additional funding and/or other resources to realize. <p>Audience:</p> <ul style="list-style-type: none"> Homeless services providers, including outreach and permanent supportive housing (PSH), with a focus on ensuring integration of CABHI program. Medicaid plan providers and Medicaid funded health service providers, with a focus on Managed Care (MCO) providers.
<p>1a. Learning Collaborative: Understanding Programs and Requirements Facilitate information sharing on how homeless service providers can connect their consumers to Medicaid funded health care services and providers and vise-versa.</p>	<p>David Shapiro (DBH)</p>		<ul style="list-style-type: none"> Create materials to educate providers about services that are available through Medicaid programs and the homeless services system. Deepen understanding of policies and procedures that impact ability to successfully refer and connect shared clients/target populations. Ensure information is updated as new



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			<p>services/resources are developed.</p> <p>Synergy with other tasks/subtasks: as and when appropriate, this would include information sharing re Task 4. Health Homes: expanding eligibility criteria to include experiencing homelessness. See below.</p>
<p>1b. Learning Collaborative: Referral System Develop referral process to coordinate access to and engagement with Medicaid services for clients of homeless services/housing providers and access to homeless services/housing opportunities for Medicaid health recipients.</p>			<ul style="list-style-type: none"> • Implement data sharing protocols and/or agreements • Research legal restrictions and draft consent templates and shared protocols for homeless services providers and Medicaid services/plan providers. • Develop business agreements between organizations <p>Synergy with other tasks/subtasks: work will inform and be informed by Task 2. Coordinated Entry: Integrate Medicaid Data and Leverage Cost Savings –particularly by the subtask 2a. Coordinated Entry: Mechanism for Realizing Cost Savings. See below for additional details.</p>



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<p>1c. Learning Collaborative: Memorializing Relationships Implement/foster contractual relationships to ensure care coordination for highly vulnerable, high cost homeless consumers identified through coordinated entry and Medicaid cost data – initial pilot with opportunities for expansion.</p>			<ul style="list-style-type: none"> Models to consider include: Houston where MCO pays community partners for outreach to engage homeless members. Explore options for tying housing resources (PSH and Targeted Affordable Housing) to an MCO that commits funding for some services – process to identify targeted consumers maybe through coordinated entry. (MCO/TAH project could serve chronically homeless people who do not score for PSH) <p>Synergy with other tasks/subtasks: work will inform and be informed by Task 2. Coordinated Entry: Integrate Medicaid Data and Leverage Cost Savings, especially subtask 2b. Coordinated Entry: Mechanism for Realizing Cost Savings and 2c. Coordinated Entry: Options for High Cost Users Not Prioritized Under Coordinated Entry. See below for additional details.</p>
<p>1d. Learning Collaborative: Identifying Needs & Developing Capacity to Bill to Medicaid Developing/creating capacity of homeless services and PSH providers to provide Medicaid reimbursed services and diversify payment sources for services, including case management.</p>	<p>DHCF, in partnership with ICH</p>	<p>Timeline: Longer term</p>	<ul style="list-style-type: none"> Depends on existing capabilities and interest Focused on providing technical assistance to homeless services providers, including outreach and permanent supportive housing. Some options include: <ul style="list-style-type: none"> DHCF to provide overview of requirements to bill to Medicaid: ID services available under Medicaid and eligibility requirements



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			<ul style="list-style-type: none"> ○ ICH, with the help of HUD TA providers, to help providers assess their ability to meet the requirements to bill to Medicaid. <p>Synergy with other tasks/subtasks: as and when appropriate, this would include capacity building around Task 4. Health Homes: expanding eligibility criteria to include experiencing homelessness. See below.</p>
<p>2. Data Sharing and Analysis The homeless services system uses coordinated entry to prioritize the most vulnerable individuals experiencing homelessness for housing opportunities and resources. Integrating Medicaid cost data into the Coordinated Entry process will allow both systems to identify the most vulnerable individuals that are also Medicaid high cost users and leverage realized savings into additional housing resources, when and as possible.</p> <p>2a. Data Sharing and Analysis: Infrastructure and Capacity Building Develop infrastructure for data sharing in real time. Develop capacity to identify Medicaid high cost users on the coordinated entry</p>	<p>SIM Community Linkages (contact Dena Hasan (DHCF), dena.hasan@dc.gov)</p> <p>ICH (Coordinated Entry Team) and DHCF</p>	<p>Priority: High</p> <p>Timeline: Immediate and Mid-term</p>	<p>Resources & Level of Effort:</p> <ul style="list-style-type: none"> ● In addition to the core tasks listed, other opportunities for data bumps and referral/coordination include: <ul style="list-style-type: none"> ○ Analysis of VI-SPDAT scoring and EPD waiver services to ensure that EPD waiver services are targeted to the most vulnerable. ○ Analysis of hospital stay data to reconnect with missing/disconnected individuals who are on the BOLO (Be On the Look Out) list ○ Analysis of Medicaid data to identify demand for medical respite beds (based on hospital and nursing homes stays and releases) and create appropriate opportunities for housing. <p>Audience:</p> <ul style="list-style-type: none"> ● Homeless services providers, including outreach and



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<p>registry. Target for housing, as appropriate. Identify characteristics and numbers of people who are prioritized for housing through coordinated entry, who are also eligible for (or already receiving) the types of Medicaid services that could be better aligned with supportive housing (e.g. Medicaid home and community based services for seniors and people with disabilities, or addiction recovery services)</p> <p>2b. Data Sharing and Analysis: Investing Cost Savings into Housing Establish mechanisms for redirecting savings realized (by housing the most vulnerable high cost users) into opportunities and funding for housing resources.</p> <p>Also, explore options for Medicaid high cost users that are not prioritized under coordinated entry. Determine potential for leveraging Medicaid savings into a housing resource for said clients. Leverage predictive analysis that identifies future high cost users.</p>			<p>PSH.</p> <ul style="list-style-type: none"> Medicaid plan providers and Medicaid funded health service providers. <p>Synergy with other tasks/subtasks: work will inform and be informed by Task 1. Learning Collaborative – particularly by the subtask 1b. Learning Collaborative: Referral System and 1c. Learning Collaborative: Memorializing Relationships. See above for additional details.</p>
<p>3. Adult Day Health Programs (ADHP): Serving Older Adults Experiencing</p>	<p>SIM Community Linkages (contact Dena Hasan)</p>	<p>Priority: High</p>	<p>Resources & Level of Effort:</p> <ul style="list-style-type: none"> Potential immediate and low hanging fruit: leverage



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<p>Homelessness and PSH Tenants Connect older adults experiencing homelessness and PSH tenants to the medical services provided by ADHP Centers that can support their service needs. As needed, expand access to and availability of ADHP centers.</p>	<p>(DHCF), dena.hasan@dc.gov Trina Dutta (DHCF)</p>	<p>Timeline: Immediate and Near Term</p>	<p>existing centers/centers in the pipeline</p> <ul style="list-style-type: none"> Potential mid/longer term: leverage creation of new Homeward DC Daytime Services Center, if feasible. <p>Audience:</p> <ul style="list-style-type: none"> Homeless services providers, including outreach and PSH. Adult Day Health Program Providers
<p>3a. ADHP: Working with Existing/Pending Day Centers Conduct an analysis to determine whether existing/pending can serve older adults who are/have been homeless and have co-occurring behavioral health disorders. Address gaps in capabilities and enroll older adults experiencing homelessness & PSH tenants.</p> <p>5 Providers are currently certified. Previously licensed as Day Treatment Programs with existing Certificates of Need.</p>		<p>Immediate</p>	<ul style="list-style-type: none"> Gaps analysis to confirm existing programs have expertise and bandwidth to meet needs of homeless/formerly homeless (age 55+, frail & need medical supervision). Explore low cost solutions/options to address gaps, including co-locating staff and services and Develop policies and procedures to enroll/connect elderly experiencing homelessness or currently living in PSH to programs.
<p>3b. ADHP: Assessing Options for Increasing Day Centers Depending on gaps identified in existing/pending Day Center programming and/or capabilities, explore creating additional</p>			<ul style="list-style-type: none"> Outline approval process for creating Day Health Programs and challenges. Identify interested partners with expertise to provide the health services and the capabilities to navigate the approval process.



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<p>programs that are tailored to the needs of older adults who are/have been homeless and have co-occurring behavioral health disorders.</p>			<ul style="list-style-type: none"> Consider incorporating/co-locating ADHP in the Daytime Services Center to be developed under Homeward DC Strategic Plan.
<p>4. Health Homes: Expanding Eligibility Criteria Develop second Health Homes benefit for people with a chronic condition and a risk factor for a chronic condition - include homelessness in eligibility criteria</p> <p>Possible model is California Health Homes proposal</p> <ul style="list-style-type: none"> Make chronic homelessness an indicator of acuity Make health home services available to high-cost/ high-need people who do not have serious mental illness (aren't eligible for the Health Home benefit being launched now) <p>Includes capacity building for providers.</p>	<p>SIM Care Delivery (contact Joe Weissfeld (DHCF), joe.weissfeld@dc.gov)</p> <p>Shelly Ten Napel (DHCF)</p>	<p>Priority: High</p> <p>Timeline: Midterm (FY 2017)</p> <p>SPA submission by spring</p>	<p>Resources & Level of Effort:</p> <ul style="list-style-type: none"> Opportunity to fold work into SIM process <p>Audience:</p> <ul style="list-style-type: none"> DHCF specific task with input from Homeless services providers, including outreach and permanent supportive housing. <p>Synergy with other tasks/subtasks: work will likely include a capacity building component which should leverage Task 1. Learning Collaborative, particularly subtasks 1a. Learning Collaborative: Information Sharing and 1d. Learning Collaborative: Identifying Needs & Developing Capacity to Bill to Medicaid.</p>



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<p>5. Case Management: Understanding & Streamlining Provision of Services Goal is to understand how case management is defined by the homeless services and PSH programs as well as Medicaid funded services and providers. With a better understanding, can identify gaps as well as areas of duplication and redundancies and model options for streamlining and assigning responsibilities (e.g. lead coordination vs specialized services), as appropriate.</p>	<p>SIM Community Linkages (contact Dena Hasan (DHCF), dena.hasan@dc.gov)</p> <p>DHS lead, in partnership with Shelly Ten Napel (DHCF)</p>	<p>Priority: High Timeline:</p>	<p>Resources & Level of Effort:</p> <ul style="list-style-type: none"> • Potential immediate and low hanging fruit: leverage Cross Connect already underway (managed by DHS) • Potential overlap with information sharing. • Potential Opportunities for Funding may include <ul style="list-style-type: none"> ○ Funding case management as a Health Home Service ○ Addressing funding gaps, including Health care conversion foundation resources <p>Audience:</p> <ul style="list-style-type: none"> • Homeless services providers, including outreach and PSH. • Medicaid plan providers and Medicaid funded health service providers.
<p>6. Incentivize Collaborations & Update Policies/Practices When providing new funding (eg. PHSP), explore potential to incentivize innovations and collaborations that</p> <ul style="list-style-type: none"> • Align Medicaid and non-Medicaid resources • Encourage multiple funding sources to pay for services in a project or a team providing services to PSH tenants. • Increase expectations that providers will have braided funding (ex. Set RFP so that 	<p>DHS (HUD TA providers available to support with developing and also reviewing proposals).</p>	<p>Priority: Immediate (PSHP opportunity) and Longer Term (outreach post-CABHI grant)</p>	<p>Resources & Level of Effort:</p> <ul style="list-style-type: none"> • Potential SIM work groups tackling similar work: Payment Models WG (approaches for shared savings, pay for performance and bundled payments, etc) <p>Audience:</p> <ul style="list-style-type: none"> • DHS, DBH and DHCF. • With particular attention to <ul style="list-style-type: none"> ○ funding availability under PHSP and ○ planning for sustainability of outreach activities post-CABHI grant.



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<p>half of PSHP funding will be for projects that have 50% of funding from other sources)</p> <p>Also, develop strategy for ensuring that, post CABHI grant, outreach teams can continue to deliver services. Assess role of Medicaid for funding continued work.</p>			<p>Synergy with other tasks/subtasks: based on outcomes of all the tasks outlined above, this work should include updating funding policies and practices to reflect leveraged resources and streamlined definition of case management.</p>