Community Integration Services: Rapid Cycle Assessment 2022-Q3

DECEMBER 2, 2022

UNIVERSITY of HAWAIʻI®
MĀNOA

Table of Contents

Overview.. 2

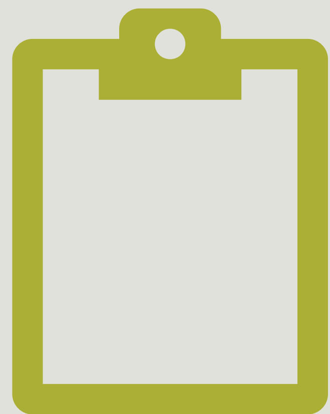
CIS Implementation Phases 3

2022 Ongoing Implementation 7

Challenges... 8

Successes... 11

Conclusions & Recommendations... 12



Overview

This report presents findings from the 2022 Quarter 3 (Q3) Rapid Cycle Assessment (RCA) for Community Integration Services (CIS). Covering the reporting period July 1, 2022 through September 30, 2022, Health Plan (HP) Q3 reports were originally due on October 31, 2022. Med-QUEST Division (MQD) extended the deadline to January 31, 2023 to allow HPs time to work on data quality concerns and to implement new reporting tools with data validation functions. To facilitate this process, MQD contracted with the Public Consulting Group (PCG). Due to the postponement of quantitative data submissions for this quarter, this evaluation report focuses on the CIS implementation process using qualitative data collected during Q3 and previous reporting periods.

Data includes qualitative responses to questionnaires submitted quarterly by the HPs as well as data from interviews conducted with all five HPs in both Fall 2021 and Fall 2022. This report focuses on changes in program implementation, continuing challenges/emerging challenges, and progress towards implementation goals. These results were shared with the HPs, Med-QUEST(MQD), and participating homeless service providers at the Rapid Cycle Assessment meeting, held over Zoom on December 2, 2022.

Over this last quarter, the evaluation team has worked with Med-QUEST, HPs, and the PCG team to improve the data submission process. Hoping to further streamline the process, the evaluation team scheduled RCA meetings for the 4th Friday after the due date for CIS report submissions at 9am starting in 2023.

The remainder of this report presents CIS implementation phases and progress in CIS implementation, including challenges and successes and conclusions/recommendations for MQD, HPs, the evaluation team, and the overall CIS team moving forward.

For more information about this report, please contact:
Anna Pruitt, PhD | annars@hawaii.edu or
Jack Barile, PhD | barile@hawaii.edu

CIS Implementation Phases

In Fall 2021, the evaluation team conducted five focus group—one per HP—with 32 individuals. Based on these discussions, the evaluation team developed the following CIS implementation framework to describe the roll out of CIS here in Hawaiʻi. This framework identifies the processes that HPs believed would facilitate successful program implementation as well as identifies what steps they were taking as part of these process. At the time of the interviews, most of the five CIS-participating HPs in Hawai'i were in the pre- or early implementation phase. As of the Fall 2022 interviews, all had moved into full and ongoing program implementation. However, because implementation is iterative, processes in pre- and early phases continue to impact implementation into 2022.

This section briefly describes each phase and the issues identified during the first round of interviews in 2021. Then, the next section describes ongoing and emerging challenges and successes now that the program has moved into full and ongoing implementation in 2022.

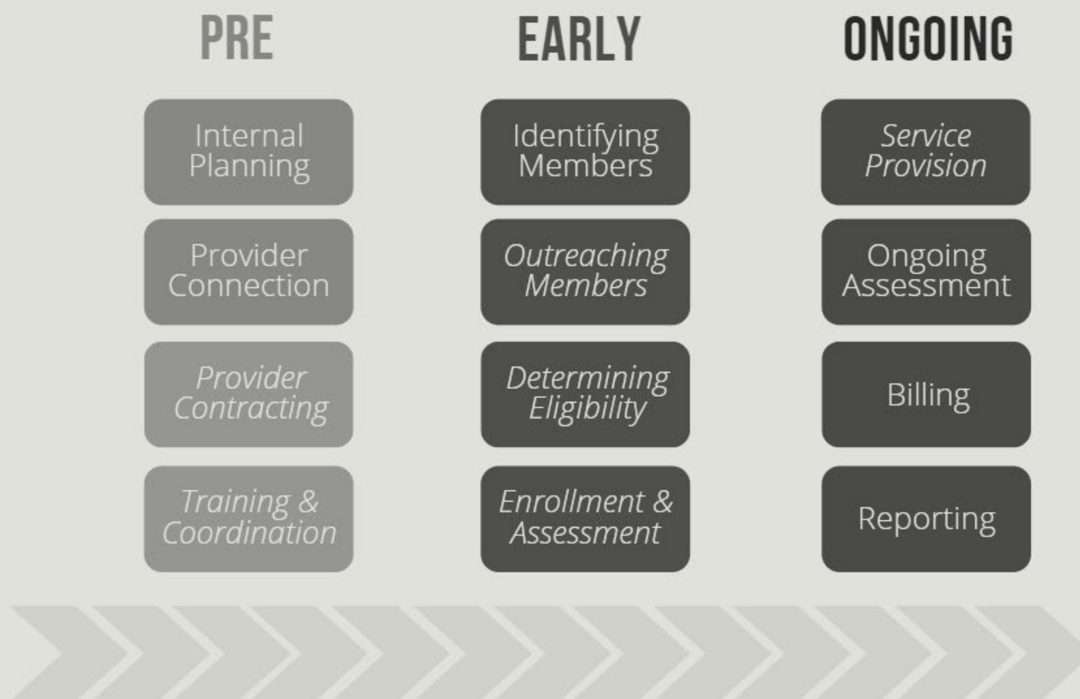


Fig. 1. CIS Implementation Phases and Steps, 2021

Pre-Implementation

Pre-implementation involved steps that HPs identified as necessary prior to CIS implementation, including internal planning, connecting & contracting with homeless service providers (HSPs), and training & coordinating with HSPs. Identified challenges at this stage were difficulties contracting with HSPs and determining workflow.

Contracting with HSPs

HPs saw contracting with HSPs as essential to ensuring the provision of CIS services to vulnerable clients. HPs reported that this process was held up by provider application delays at the state-level. These delays were in part due to “snags” with enrollment in MQD’s web-based provider enrollment system: Hawaii's Online Kahu Utility (HOKU). As of October 2021, only a small number of HSPs were interested in participating in CIS and even less had successfully completed the application process. HPs continued to build relationships with HSPs in an effort to help build capacity and navigate the HOKU system.

Determining Workflow

HPs reported that determining workflow both internally and between HPs and HSPs was an important pre-implementation step. Unfortunately, confusion over memo requirements (particularly, conflict-free case management) and contradictions between MQD verbal and written communication held up this process. At the time of the focus groups, it was unclear who would be performing important program activities, including outreach and assessments. While HPs agreed that HSPs should do these activities, the conflict-free case management requirement made it unclear if those providing services could also perform assessments.

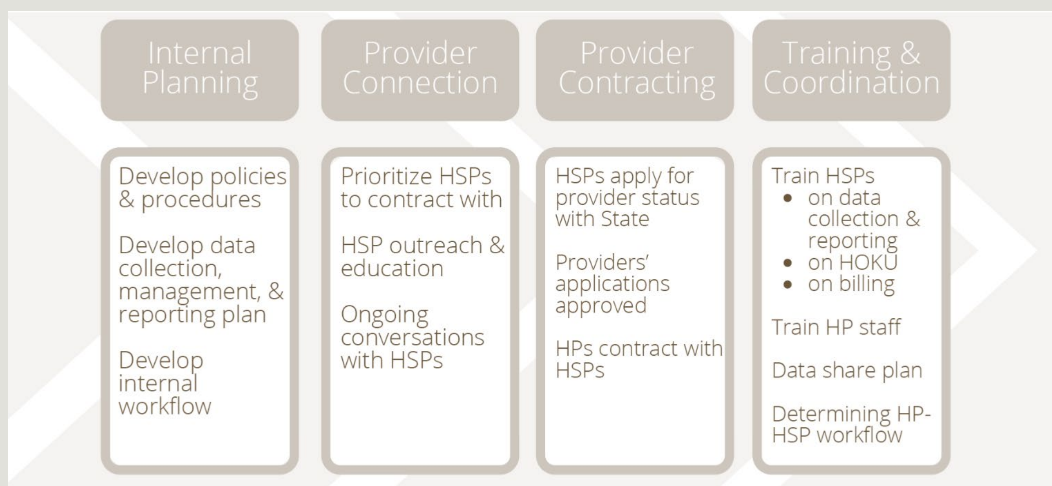


Fig. 2. CIS Pre-implementation Phase and Essential Activities, 2021

Early Implementation

Early implementation includes identifying and outreaching potentially eligible members, verifying eligibility, followed by enrollment and assessment. Some of the key issues at this phase included challenges sharing data across systems and with outreaching hard-to-reach members without having contracted with HSPs.

Info/Data Sharing & Reporting

Sharing data and information are necessary both for reporting and coordination of care. HPs noted that sharing this information was complicated by the lack of existing infrastructure for sharing data across systems. HSPs Additionally HPs had limited Access to Homeless Management Information System (HMIS) data that is used by homeless service system to track clients.

Outreaching Members

Members who are eligible for CIS (e.g., those experiencing housing insecurity) are often those members who are most difficult to reach. HPs reported that it was difficult to find referred members who were living on the streets and relied heavily on HSPs to outreach these members. However, because of delays in contracting with HSPs and difficulties sharing information, HPs noted that identifying, outreaching, verifying eligibility, and assessing took longer than anticipated as members could fall through the cracks at each step.

Fig. 3. CIS Early implementation Phase and Essential Activities, 2021

Ongoing Implementation

At the time of the Fall 2021 focus groups, no HPs had yet provided services through CIS. However, they explained what processes were in place and what activities were planned for full CIS implementation. For example, HPs pointed to service provision, ongoing assessment, billing, and reporting as key steps in ongoing CIS implementation, identifying specific activities and anticipated challenges at each step. The primary anticipated challenges included concerns around billing as well as balancing requirements with HSP capacity.

Balancing Requirements with HSP Capacity

HPs noted that HSPs must navigate two separate and complicated systems (housing and healthcare) and five different processes for sharing information and data. While the five HPs worked together to try to develop similar processes, each HP still had a separate CIS process and workflow. HPs also indicated that they were concerned about assessment length. Coupled with assessments and forms required by the homeless service system and the HSP agencies, CIS forms would add a considerable amount of time to the intake process and could potentially be a barrier for members. Evaluators also noted that HSPs would be carrying the bulk of the program's responsibilities (providing services, conducting assessments) while having the least capacity to do so. Local HSPs are primarily non-profits who provide direct services by piecing together various funding. They do not usually have large administrative departments to manage the billing and reporting required by HPs.

Anticipated Billing Concerns

Medicaid billing and homelessness services funding streams operate quite differently. Homelessness services funds are often bundled (e.g., a shelter program may be funded through a grant that provides a lump sum per person that includes case management, housing navigation, and vouchers). These funding streams come with their own requirements for reporting and evaluation. HPs noted that HSPs were unsure how to implement CIS without "double-dipping" as services cannot always be unbundled.

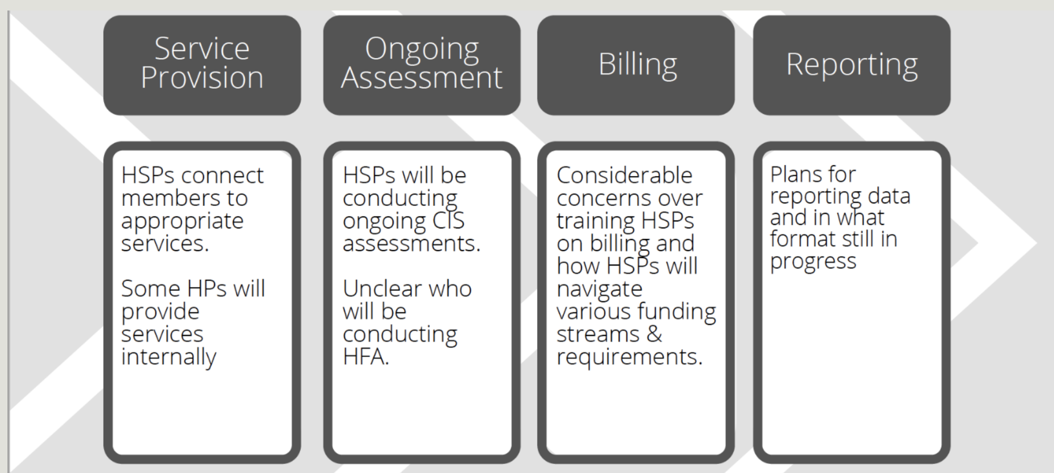


Fig. 4. CIS Ongoing implementation Phase and Essential Activities, 2021

2022 Ongoing Implementation

The UH Evaluation team met with representatives from each HP in October 2022. Whereas the previous year's interviews were with entire CIS teams, this year, the evaluation team asked to speak to the person or persons from each HP who were responsible for overseeing and coordinating CIS personnel and the day-to-day CIS activities (i.e., a program coordinator). However, some upper-level administrative staff also attended these interviews. The evaluation team interviewed a total of 10 people from five Health Plans. Five of the interviewees had also participated in the Fall 2021 focus groups.

Interviews revealed continued challenges from Fall 2021 as well as emerging challenges that cut across implementation phases to impact direct service provision. Continued challenges from fall 2021 included:

- Small number of HSPs participating in CIS;
- Inconsistences between memo and MQD verbal communication;
- HSP difficulty navigating five separate processes across the five HPs;
- Assessments reported to be lengthy and redundant; and
- Concerns and confusion about billing.

This section describes some of these challenges and the steps taken to overcome them as well as some success reported by the HPs.

2022 Implementation Challenges

The 2022 challenges identified by HPs can be grouped by themes including:

- Finances and Billing
- Synchronization across HPs
- MQD Communication
- HSP Capacity
- Assessments
- Data Quality

Finances and Billing

HSPs experienced concerns with finances and billing, particularly:

- "Double Dipping"
  - As predicted in 2021, HSPs reported concerns over "double dipping" of resources for CIS clients. Because CIS does not include funding for housing, to house CIS members, HSPs often must combine CIS with other housing programs. Housing programs typically bundle funds, providing a lump sum per participant that includes a variety of services (e.g., case management, housing vouchers, etc.). Thus, even if a member is eligible for CIS, if that member is already enrolled in a housing program, it is often not advantageous for that member or HSPs to enroll that member in CIS and risk double dipping funds.
- Claims Rejections
  - HP interviewees noted that the HPs were rejecting claims submitted by HSPs, leading to HSPs not receiving payment or receiving payment late. The reason for these rejected claims was unclear, but some HPs suggested it was due to incomplete information on the claims forms.
- Prior Authorization
  - There is currently not a united prior authorization form which requires HSPs to navigate five different systems for authorization, submitting claims, and reimbursement. HPs noted that these different forms and processes led to delays and confusion for HSPs.
- Reimbursement Style Payments
  - Given reported concerns with prior authorization, claims rejections, and "double dipping," it appears that HSPs are finding the reimbursement style payments difficult. Not only is this type of billing system a steep learning curve for HSPs, but also HSPs do not have dedicated billing offices like healthcare providers do to manage this sort of complex billing process.

Synchronization across HPs

Many of the challenges centered around issues related to five different processes for five different HPs. **In general, each health plan has their own reporting, data collection, and submission processes that HSPs must work around, which added extra stress and delays. The most difficult processes to navigate included:**

- Prior Authorizations
  - As previously noted, each HP has a different prior authorization process, requiring HSPs to learn all five processes to avoid delays in authorizations and reimbursement.
- Reporting Requirements
  - Similarly, each HP has a slightly different process for submitting claims. For example, some HPs require case notes while others do not.

MQD Communications

Confusion persisted over what to do when MQD memo and verbal communications were in contradiction. For example, HPs explained that when asking for clarification on memo requirements, that clarification was often provided verbally. Without written confirmation, HPs were hesitant to act on this communication (e.g., changing the code for conflict free case management [T-1016]).

Assessments

HPs noted that HSPs continued to express concerns over the length and frequency of assessments.

- Length and Frequency
  - Assessments take hours to complete and must be completed very frequently. This can be difficult and logistically and emotionally for this hard-to-reach population. This is particularly taxing as most members need both the CIS Assessment AND HFA regularly.
- Incomplete Assessments
  - As of now, HSPs are completing all CIS assessments. This can be a large burden on the HSPs who do not have capacity and can lead to HPs not submitting completed datasets for the RCA.

HPs mentioned previous conversations with MQD about shortening assessment and/or combining with the Health and Functional Assessment (HFA), but no updates have been given as of yet. Indeed, the evaluation team worked with MQD earlier in 2022 to shorten the CIS assessment and combine it with the HFA.

Data Quality

Data quality continued to be an issue into 2022. Issues tend to be related to the following:

- Incomplete Data
  - HPs' quarterly reports continue to have large amounts of missing data and/or contradicting numbers. HPs noted that they often received incomplete data from HSPs as well as experienced challenges finding members to collect data.
- Incorrect Formulas
  - Previous reporting tools had incorrect formulas, which added extra confusion and stress for HPs.
- Hard Copy Submissions
  - Some HPs and HSPs are utilizing hard copies and faxes to send assessments and data between each other. The lack of electronic submission slowed down the data collection and reporting process.

- Data Sharing
  - Not all Health plans have access to HMIS and/or Bridging the Gap. Additionally, access is read only and is not always updated regularly.

The evaluation team is working with PCG to improve the data submission process and correct formulas in the reporting tools. Additionally, PCG is working directly with HPs to assist in collecting and reporting high quality data.

HSP Capacity

Many of the challenges were exacerbated by or contributed to the lack of HSP capacity to implement CIS as designed. For example, HSP capacity affected:

- Number of Clients Served
  - As of 2022, a small number of HSPs were providing CIS. While more HSPs were contracted than in 2021, many were not providing services because they lacked the capacity to do so. Even the two largest HSPs in the state did not have the capacity to serve more than 20 members per plan at a time.
- Data Completion
  - HPs require participating HSPs to handle the bulk of assessment and reporting. HPs reported that they often receive incomplete data from HSPs given lack of capacity coupled with lengthy assessments.

Some HPs mentioned HSPs are concerned that the hassle of implementing CIS is not worth the expected benefits.

2022 Implementation Successes

Despite these challenges, HPs reported successes as well as strategies that helped to overcome some of these issues. Some of these successes include:

- Community Integration
  - Health Plans reported becoming more integrated into community, both with contracted HSPs and other community partners and behavioral health services.
- Collaborations
  - MQD, HPs, and HSPs have been working together to develop and implement CIS. HPs meet with MQD weekly and each reported regular communication between health coordinators and HSPs.
- Increased Homeless Service Provider Participation
  - As of October 2022, HPs were actively working with 10 HSPs across the state—compared to one in fall 2022.
- Resolving Issues
  - Previous issues, such as conflict-free case management, seem to be mainly resolved as HPs and MQD work through emerging issues with implementation..
- Commitment to Improved Data Quality
  - While still an issue, data quality has been slowly improving. HPs are grateful for PCG assistance and weekly office hours. Additionally, HPs had more specific questions for the evaluation team for how to improve data quality moving forward.

Conclusions and Recommendations

Many of the challenges related to CIS implementation are related to the capacity of HSPs to take on the bulk of CIS programming. The success of CIS relies heavily on HSPs, and it is imperative that they have the support they need to implement the program. It is also important that the program meets the needs of HSPs and members experiencing housing insecurity.

General Recommendations

Based on data, the evaluation team makes the following big picture recommendations for the CIS team, which includes MQD, HPs, the evaluation team, HSPs, and beneficiaries:

- **Reduce HSP burdens.** A lot of this program's success depends on HSPs. A lot of the burden also falls on them, and they have the least capacity to take on that burden. HSPs are not typical healthcare providers and should not be expected to operate in this way given they do not have the capacity to do so.
  - In addition to reducing burdens, consider supplying funds that could help build capacity (e.g., hire more staff, hire someone to handle billing, etc.).
- **Take a step back to consider what the homeless service system needs.** CIS was developed from a healthcare perspective while relying disproportionately on homeless service providers to implement it. The CIS team might conduct a needs assessment with the local Continuum of Care and HSPs to ask what they need and how this program might be adjusted to meet those needs.
- **Develop a prioritization process** given that there are more eligible members than HSPs can serve.
- **Continue to use RCA meetings as a space to develop a health and housing network**, where stakeholders, including members with lived experience, can come together to brainstorm ways to improve program implementation and collaboration across systems.

Additionally, the evaluation team makes specific recommendations by stakeholder: HPs, MQD, and itself.

Recommendations for Health Plans

- Internally **review common causes of rejected claims** and work with HSPs to build capacity to address these issues or adjust internal policies regarding claims submitted by HSPs.
- Continue to **send formulas errors to PCG** team and consult them on data quality issues and questions.
- **Use the evaluation team as a resource**. If running into issues with program implementation or data collection, reach out to the team who can provide consultation on current research and best practices.
- Continue to look for ways to **reduce HSPs burdens** by assisting with locating members, conducting assessments, and billing.

Recommendations for MQD

- Send out **written updates on verbal communications** from meetings. Consider compiling and posting all questions and answers in writing in a public place (e.g., posting meeting transcriptions if available)
- Consider **adjusting time windows** for some key performance indicators (KPIs) (e.g., length of time between eligibility confirmation and consent; between referral and eligibility confirmation).
- Consider developing a **universal prior authorization form** and provide instruction on the claims process regarding case notes.

Recommendations for Evaluation Team

- Continue to work with MQD to **reduce assessment length**. In particular:
  - Integrate CIS Assessment into HFA;
  - Remove redundant questions; and
  - Review HSP intake procedures and forms that may also result in redundancy.
- **Interview HSPs** to understand implementation on the ground and direct service provision.
- **Interview members** enrolled in CIS to understand program impacts as well as ongoing member needs.