Community Integration Services: Rapid Cycle Assessment 2022-Q4

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Overview

This report presents updates from the 2022 Quarter 4 (Q4) Rapid Cycle Assessment (RCA) for Community Integration Services (CIS), covering the reporting period October 1, 2022, through December 30, 2022. This RCA was supposed to include data submitted by Health Plans (HPs) for both 2022 Quarter 3 (Q3) and 2022 Q4. The Q3 reports were originally due on October 31, 2022, but 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), who provided technical assistance and data validation tools to HPs. PCG reviewed the January 31st submissions and provided feedback to HPs, allowing for resubmission of reports that did not meet data quality standards. Notably, none of the submitted HP reports included 2022 Q3. Thus, this RCA report only covers 2022 Q4.

Because 2022 Q4 report data quality was still under review by PCG at the time of the scheduled RCA meeting on February 24, 2023, the RCA presentation focused on bringing in best practices and lessons learned from other states implementing similar Medicaid-funded housing support services. During the RCA meeting, the evaluation team shared findings from other states and facilitated problem-solving discussions among attendees which included members from the five HPs, MQD, and participating homeless service providers (HSPs).

The remainder of this report reviews the information shared at the RCA meeting as well as reports on CIS in Hawai'i using the limited 2022 Q4 data submitted on January 31, 2023 that met data quality standards at the time of the RCA meeting.

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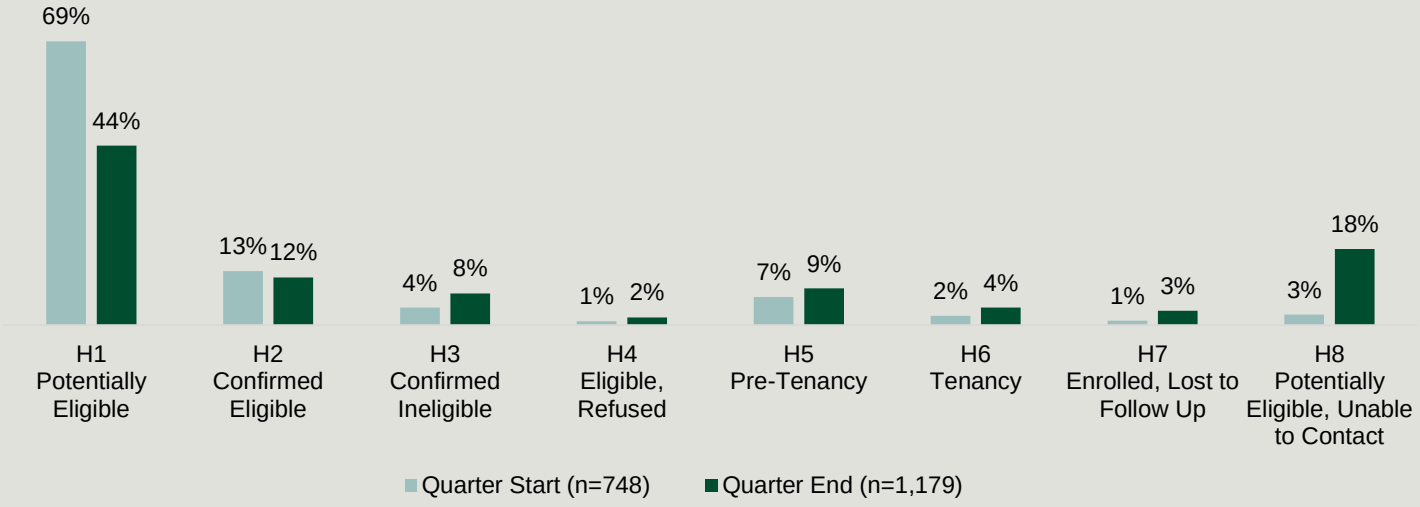
CIS Hawai‘i

To determine the number of people eligible for and receiving CIS, the evaluation team examined member H code statuses at the beginning and end of the quarter using data submitted by the HPs. MQD uses “H codes” to designate and track member status in CIS and requests that HPs submit data quarterly on any member assigned to any of the H code statuses during the quarter. A total of 1,208 members had any H code status at any time during 2022 Q4. A total of 748 members had an H code status at the beginning of the quarter, and 1,179 at the end of the quarter (members can gain or lose H code statuses at any time during the quarter). The majority of members with any H code status at the beginning of the quarter was assigned to H1 (69%; *n*=516; “potentially eligible”). The percentage dropped to 44% (*n*=329) by the end of the quarter. However, the percentage of members assigned to H8 (“potentially eligible, unable to contact”) increased over the quarter, suggesting the decrease of members in H1 was offset by the increase of members in H8. In other words, a bottleneck likely exists in determining eligibility.

Overall, a small percentage of members with any H code status during the quarter was receiving CIS services at the beginning of the quarter. Seven percent (7%; *n*=51) were receiving pre-tenancy (H5) services, and 2% (*n*=17) were receiving tenancy (H6) services. These percentages increased slightly by the end of the quarter to 9% (*n*=105) and 4% (*n*=50), respectively. No members transitioned from pre-tenancy (H5) to tenancy (H6) during Q4.

Fig. 1. Percent of CIS Members by H Code Status at 2022 Quarter 4 Start & End



In 2022 Q4, the five HPs collectively reported that 105 members were newly "enrolled" in CIS, and 42 were newly "disenrolled", with 974 members having been enrolled at any time during the quarter. However, H Code status data suggests that only 162 members were ever received services in Q4 and that 408 members moved to disenrollment/exited H code statuses (H3-4, H7-8), suggesting confusion as to what it means to be enrolled in CIS. Only a small percentage of members with any H code at the quarter's end were receiving tenancy or pre-tenancy services.

Fig. 2. H Code Status at End of 2022 Quarter 4 (*n*=1,179)

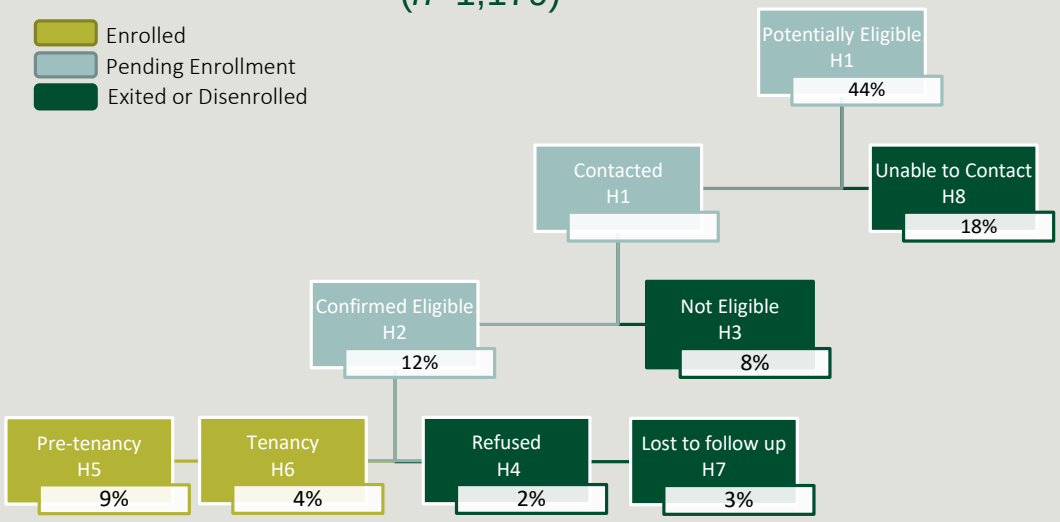
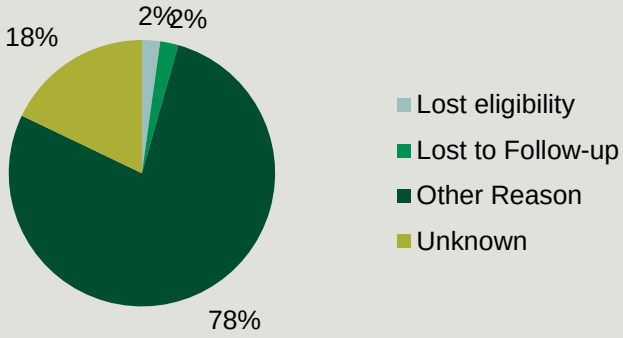


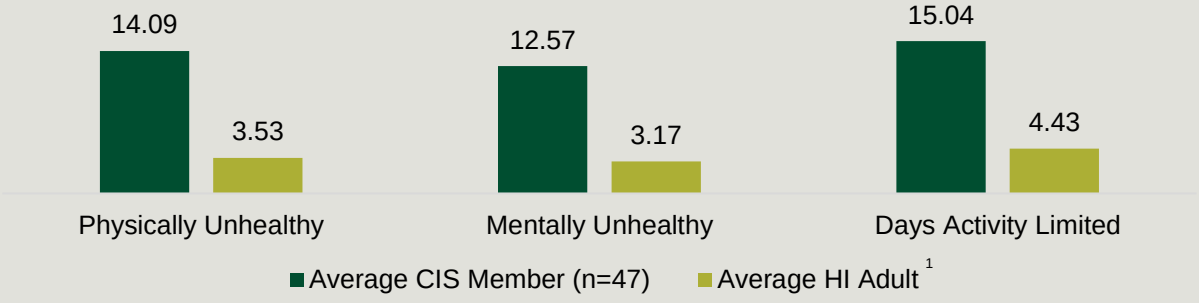
Fig. 3. Disenrollment or Exited Reason (*n*=408)



The vast majority of disenrollment reasons reported in Q4 included "other" and unknown reasons. Neither H code status nor report templates allow for more detailed disenrollment data. Thus, the evaluation team is unable to examine whether a member exits the program into housing or to a houseless destination—an important indicator of program success.

Of the 162 members who have received tenancy or pre-tenancy services in Q4, 47 have assessment data reported. This data shows that these members reported high numbers of unhealthy days on average, much higher than those reported by the average Hawai'i adult, suggesting that CIS is serving highly vulnerable members as intended.

Fig. 4. Ave. # Unhealthy Days Reported in Last 30 Days



[1]U.S. Centers for Disease Control. (2021). Behavioral Risk Factor Surveillance System (BRFSS) 2021.

CIS in the United States

Since 2007, A total of 29 states and Washington D.C. have implemented or are in the process of developing programs that resemble Hawai'i's Community Integration Services (CIS) program. Of these programs, 16, including Hawai'i's, are funded through the 1115 Waiver mechanism. While strategies vary, these programs offer a variety of tenancy and housing supports billable to Medicaid. During the February 24, 2023 RCA meeting, the UH team outlined key challenges and successes that some of these states have faced in an effort to inform program implementation and service delivery here in Hawai'i.

Fig. 5. US States with CIS-Type Services

- 2007-Louisiana
- 2016-California*
- 2017-Washington*
- 2017-Maryland*
- 2017-Pennsylvania
- 2018-Illinois
- 2018-North Carolina*
- 2018-Hawai'i*
- 2019-Florida*
- 2019-Michigan*
- 2020-Massachusetts*
- 2020-Minnesota
- 2020-Rhode Island*
- 2020-Texas
- 2020-Virginia*
- 2021-Colorado
- 2021-Connecticut
- 2021-Montana*
- 2021-New Jersey*
- 2021-North Dakota
- 2021-Oregon*
- 2021-Wisconsin
- 2022-Arizona*
- 2022-Washington DC
- 2022-Vermont*
- *In planning-Nevada*
- *In planning-New Hampshire*
- *In planning-Utah**
- *In negotiation-New Mexico*

*Funded through 1115 Waiver

Corporation for Supportive Housing. (2022). *Summary of state actions Medicaid & Housing Services*. Summary of State Actions. Retrieved March 9, 2023, from https://www.csh.org/wp-content/uploads/2022/10/CSH-Summary-of-State-Action-Medicaid-and-Supportive-Housing-Services-Fall-2022.pdf

Common Challenges

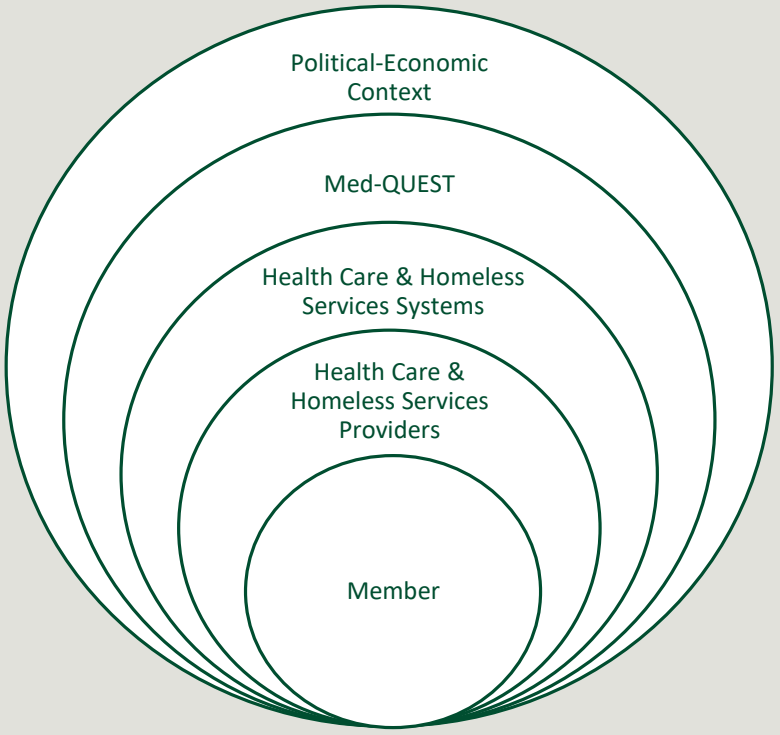
Experiences of other states that are further along in the implementation process offer the opportunity for Hawai‘i to benefit from their lessons learned. The Rutgers Center for State Housing Policy (Thompson et al., 2021) identified common challenges among states who were early adopters of Medicaid-funded tenancy supports. Many of these issues overlap with the challenges experienced by Hawai'i's CIS program.

The evaluation team organized these challenges within a multilevel framework (see Fig. 6). Taking a multilevel approach to program implementation and evaluation can help stakeholders identify how challenges at one level can impact other levels as well as can be useful in determining what challenges are solvable and by whom. The team hopes that outlining these shared challenges within a multilevel framework as well as reviewing successes from other programs will help HPs, HSPs, and MQD build a successful program in Hawai‘i.

Housing Supply Issues

One of the most common challenges involves housing supply. While referring to the lack of affordable housing broadly, particularly for low-income renters, housing supply issues also include lack of enough housing subsidies to meet needs and limitations as to what the Medicaid support covers (e.g., inability to use funds to pay rent). Additionally, finding appropriate housing for special needs members can be challenging. While this issue is largely dictated by the political-economic context—and thus, outside of the control of the HPs and providers—it is an issue that impacts every other level, including the CIS member.

Fig. 6. Community Integration Services Multilevel Framework



Bridging Two Siloed Systems: Health Care & Homeless Services

The coordination between health care and housing services is vital to the success of a program like CIS. These systems are complex and often siloed. CIS-type programs have struggled to bridge the two sectors without overburdening either HPs or HSPs, both of whom often struggle to find a shared language. Almost every other challenge identified is related directly or indirectly to this issue.

Enrolling and Retaining Members

Many states, Hawai'i included, have difficulty enrolling and retaining members in CIS-type programs. One reason for this difficulty includes the fact that members belonging to a population that is medically vulnerable and experiencing housing instability/homelessness are hard to reach because of those vulnerabilities. Typical strategies for engagement do not work (e.g., phone calls, mailers), and reaching these members requires coordination between HPs and HSPs. Additionally, determination of eligibility and subsequent enrollment require access to both homelessness services and Medicaid systems that are not easily accessible across silos. These roadblocks can lead to "churning enrollment" as members are lost to follow up and lose eligibility despite still needing the benefit (Thompson et al., 2021, pg. 20). Thus, systems-level issues have direct consequences for members, with those experiencing housing instability being most at risk for not being enrolled in programs for which they qualify.

Contracting with and Paying Homeless Services Providers

Also directly related to bridging health and homeless services, one major challenge is the process of contracting and paying the homeless service providers participating in CIS. The contracting process is often long and tedious and is an administrative burden for HSPs. Once contracted, HSPs often lack the capacity to manage and submit claims, resulting in rejected claims and delayed payment, which is often inadequate to cover costs of service provision. HSPs also face "supplantation" challenges which involve piecing together multiple funding sources to serve members while ensuring that funding sources do not overlap (Thompson et al., 2021, pg. 24). All of these challenges are exacerbated by the fact that many CIS-type programs don't not cover start-up funding or overhead costs, which are necessary to implement the program at the HSP level.

Recruiting and Retaining Staff

An integrated health and housing program requires many types of staff working together on the same program and with the same members. Beyond the challenge of hiring the staff, a difficulty reported across industries nationwide, successfully building a cohesive unit of staff across sectors is a common challenge and leads to retention issues. Additionally, HPs and HSPs nationwide reported recruiting difficulties due to the lack of job security that the impermanence of a waiver demonstration creates. They also noted difficulties finding staff that have both the skills to provide services and to document and bill for them. Often the individuals who are most skilled at providing direct services are those with less formal training and qualifications.

Durability beyond Current Waiver

Another concern regards the uncertainty about the continuation of funding beyond the funding cycle. This uncertainty can lead to less buy-in from stakeholders given the potential for discontinuation of the program after the demonstration. In Hawai'i, this concern impacts the extent to which HSPs are willing to participate in the program—particularly small HSPs with less capacity. Given the start-up costs and administrative burden of integrating Medicaid billing into existing financial structures, many HSPs have adopted a "wait and see" approach before investing time and money into what could be a short-term program.

Successful Strategies

Despite these challenges, many states implementing CIS-type programs have seen success. For example, Washington State, Rhode Island, Minnesota, North Dakota, New Hampshire, and Washington D.C. have been recognized by the Corporation for Supportive Housing for "hav[ing] facilitated the successful implementation of the housing-related benefit" (2022, pg. 2). Examining successful strategies from other states may inform CIS in Hawai'i. The following strategies are culled from the Rutgers Center for State Housing Policy reports (Thompson et al., 2021), other states' published successes (Corporation for Supportive Housing, 2022), and successful strategies from Hawai'i's own CIS program. These strategies may serve as important recommendations or next steps to consider for CIS in Hawai'i and elsewhere.

Investment in Building Provider Capacity

Investing time, money, and resources into building HSP capacity has shown to counter potential barriers and to encourage program uptake. Both Washington D.C. and North Dakota have prioritized homeless service provider capacity-building in order to ensure growth and successful partnerships with community organizations. For example, North Dakota offers start-up funding to agencies that want to participate but need financial assistance to hire staff to manage billing, which allows contracted agencies to remain well-positioned to offer the benefit.

PMPM Payment Structure

Finding the appropriate payment structure that meets requirements and inflicts the least amount of burden is an important component of a successful implementation. Washington D.C. and Rhode Island utilize a "per member per month" (PMPM) payment structure to ensure housing providers can meeting funding needs with minimum contract requirements. Additionally, PMPM allows for providers to focus on quality services as opposed to "chasing after units of services" (Corporation for Supportive Housing, 2022, pg. 3). Minnesota's program use a combination of PMPM and "fee for service" (FFS) payments with accountable care organization (ACO) partners fronting money for direct funds for things like staff hiring or more immediate patient services. Finding the appropriate payment structure will likely depend on the types of service organizations states wish to partner with—larger organizations may be able to manage more complex payment structures whereas small community-based organizations may not have that capacity. Hawai'i is considering moving to a bundled payment structure in the near future.

Third Party Administrators (TPA)

TPAs are separate organizations who are hired on to manage certain administrative tasks such as insurance claims processing, benefits, and liaison work between stakeholders. Using a TPA may help to limit the administrative burden and prevent future burnout for Medicaid agencies, HPs, and HSPs. Washington and Minnesota employ a third-party administrator (TPA) to coordinate and act as a liaison between housing/employment agencies, Medicaid agencies, health plans, and members.

Intensive Trainings for ALL Stakeholders

One reported strategy for program success was creating unified, in-depth trainings for ALL stakeholders, including HSPs, state Medicaid agencies, and HPs to create a united process and effort. States that have seen success have engaged not only in training providers in managed care but also, and especially, providing training for the state and Health Plans, who may have limited knowledge of the housing and homelessness system.

Structural Changes to Integrating Housing and Health Care

States with successful implementations have reported making a concerted effort to integrate health and housing systems. Specifically, these states mandated coordination and frequent interaction between stakeholders, encouraging cross-sector collaborations, and creating steering committees to manage the priorities and operations of CIS. Additionally, Washington D.C. and New Hampshire integrated the housing benefit into the state coordinated entry system (CES). In Hawai'i, HPs regularly attend CES case conferencing, but CIS has yet to be integrated into CES in a systematic way, and there is no shared vision across systems as to what members of the population are best suited for CIS as opposed to other more intensive housing programs.

Data Platform Integration

Because housing and health care systems have largely remained separate prior to implementation of these programs, their workflows and data platforms are also distinct. This disconnect impacts data collection and data sharing—particularly in Hawai'i which has five HPs with five different processes. Other states have insisted that integrating the separate systems or creating a new, unified system will ease communication and data flow between stakeholders. However, details are limited on how this can be done. Currently, the State of Hawai'i is working with the University of Hawai'i and the Health Policy Initiative to develop a Health Analytics Platform that will integrate data across many systems in the state, which may serve as a guide for other states.

State Plan Amendment

Some states created an amendment through the Medicaid law Section 1915(i) to allow for more permanence and the ability to provide support for housing through Medicaid statewide. For example, Minnesota's program integrated housing services structurally into their Medicaid plan, focusing on a "housing first" method, then offering other health and lifestyle related services. This move has helped assure the housing sector agencies that services will be long-term and ongoing.

Recommendations

Learn from Other States

Although the challenges and successful strategies have come from a variety of states and sources and may not work in all cases, CIS stakeholders should take the time to consider these successes and challenges to see what might work within Hawai'i's system.

Take a Systems-Level Approach

Although each state has its own processes and workflows, one commonality with successful implementations is the development of innovative, systems-level solutions. Given the fact that many of the shared challenges include issues created or exacerbated by systems-level problems, it is no surprise that states that have adopted systems-level approaches are the most successful.

Integrate into Homelessness Services

Successful states have worked to integrate housing and health care in deliberately and collaboratively and have been flexible, adapting to changing needs in the community. For example, these states work to integrate CIS into the housing and homelessness service systems rather than expecting homeless service providers to operate CIS predominately within a health care system.

Learn from the Data

As data quality improves, the UH Evaluation Team is better able to provide analysis of program implementation data quickly. This data can help all stakeholders identify successes and potential missteps as they occur. Thus, we recommend that HPs utilize the newest data validation tools provided by PCG in order to continue improving data quality. Additionally, we recommend that MQD work with HPs to

Develop Shared Definitions

Given the discrepancy between HPs' reported enrollment numbers and HPs' reported H code statuses, there is a need for a shared understanding as to what it means to be enrolled in CIS. Additionally, it is unclear what it means to exit the program successfully (or unsuccessfully). For example, no codes exist for identifying a successful exit and no clear understanding exists for when to exit a member from services.

Develop Way to Capture Housing Outcomes

UH also recommends that MQD and the UH team work together to develop a data reporting strategy that captures housing outcomes (i.e., where people go after receiving CIS). This strategy may require developing additional H codes and/or additional data fields in the reporting tools. Related to the above recommendation, there is a need for a better way to document exit/disenrollment data.

Address the Bottleneck

Given that the majority of members with any H code assignment in Q4 were assigned to H1 or H8 (and most of the transferring between codes were between these codes), it appears that a bottleneck exists in the contacting members to determine eligibility. Likely the cause of this issue stems from many systems-level challenges (e.g., lack of provider capacity, difficulties integrating health care and housing systems). Thus, MQD, HPs, and HSPs might consider a working group that addresses this and other challenges stemming from these larger challenges.

Continue being Flexible

Data quality are improving and number of CIS recipients is increasing, suggesting that continued flexibility and adaptation to changing contexts and community needs have had the desired effects.

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