



**New York State Department of Health Medicaid Redesign Team Supportive Housing Program
2012 Scattered Site Programs**

Program Analysis and Recommendations

OVERVIEW

In 2012, as part of the New York State Medicaid Redesign Team Supportive Housing Program, the Department of Health (DOH) funded approximately \$17.5 million to create and/or link to supportive housing for approximately 1,500 High Cost Medicaid Users throughout New York State. The units were allocated to three New York State agencies that have experience funding supportive housing: the NYS Office of Mental Health (OMH), the New York State Office of Alcoholism and Substance Abuse Services (OASAS) and the Department of Health AIDS Institute (DOH AI).

Each agency had discretion to develop its own program design with the only universal requirement being that funding be used to provide High Cost Medicaid Users with housing and support services.

In the fall of 2014, the Supportive Housing Network of New York organized meetings and conference calls among MRT awardees to gather feedback on successes and challenges associated with the programs. We held three in-person meetings in New York City -- six of nine DOH AI awardees participated; eight of twelve OMH awardees participated and all four OASAS awardees participated. We also convened four conference calls with upstate providers – four of six DOH AI Rest of State awardees participated; six of fifteen OASAS Rest of State awardees attended; six of twelve OMH Long Island Mid-Hudson awardees participated; and two of fifteen OMH Western and Central NY awardees participated.

This document is a summary of feedback from those meetings and includes a list of recommendations and best practices for consideration for future supportive housing programs targeting High Cost Medicaid Users.

RECOMMENDATIONS/BEST PRACTICES

Although each individual program had its own challenges and opportunities, a number of issues and recommendations spanned all three program areas including the following:

- **Define “High Cost Medicaid User”** – While providers were confident that the people they served through the MRT scattered site programs met the eligibility criteria set out by the state agencies, they were never sure whether those criteria sufficiently targeted those most in need or the highest cost. As one provider put it: “we were fairly sure the tenants we placed were ‘higher’ cost users (than non homeless recipients), but were both unsure as to whether that constituted “high cost” or whether we were targeting those most in need of the intervention.” ***NYS should define who qualifies as a High Cost Medicaid User and/or create a triage tool that allows providers to accurately determine eligibility.***
- **Create a System to Speedily Determine Program Eligibility** – Each cohort of awardees (OMH/OASAS/DOH AI) met challenges as they tried to speedily determine potential tenants’ eligibility for MRT supportive housing. In the case of OMH criteria, eligibility was connected to Health Home eligibility, which, due to delays in Health Home development and attribution, often proved difficult to determine. In the case of OASAS, eligibility was connected to hospital utilization, information providers were barred from accessing. (OASAS overcame this obstacle by developing a unique two-day check/response system that providers applauded but which put strains on OASAS’ resources). DOH AI awardees, meanwhile, reported that they didn’t know whether clients were enrolled in Health Homes until after the first month’s claim data was returned. ***NYS should create a system that allows housing providers to check client eligibility using healthcare data in order to accurately assess eligibility.***
- **Provide Data feedback** - Currently, a provider has no way of knowing whether or not their housing-plus-services intervention is resulting in diminished use of emergency care (and/or whether additional services are needed to do so). ***NYS should share data and benchmarks with providers so they can assess whether or not they are meeting the defined goals of the program.***
- **Better Match HCMU Population to a High Need Supportive Housing Model** – The HCMU population being served in the current MRT scattered site units/programs are a high need population and in need of greater services than those currently being offered through the three programs. Providers recommended the following:

 - **Congregate Model vs. Scattered Site Model:** Because this population needs more frequent and higher level of services than can currently be supported under the scattered site model, in NYC, most providers recommended the use of a congregate model instead.
 - **Backfill Option:** Because the scattered site model did not support the level of services providers felt was needed in certain cases, some used a “backfill” strategy - they moved out a tenant living in a congregate setting unit who could live in a less service-enriched housing environment (scattered site) and then offered the unit in the congregate setting to the MRT client. There is a cautionary note in institutionalizing this model because not all providers have this option.

Further, in evaluating the cost reductions attributable to the supportive housing intervention going forward, these MRT tenants' housing costs need to be adjusted to those of the higher-cost congregate setting.

- **Rate Increase:** Virtually every provider reported that a significantly higher rate was needed to provide adequate housing and services to this very vulnerable population and that current programs do not support the higher level of services needed. At least one awardee recommended that the model incorporate peers.
- **Transfer Care Coordination Activities to Supportive Housing Providers** – In NYC, Health Home care coordinator case loads are hovering at 120:1. In Upstate it is closer to 50:1. Because the case loads are so high care coordinators are not able to provide the level of support needed. Most downstate providers expressed a frustration with never seeing the care coordinators and having to take on their responsibilities in-house. Going forward, the recommendation is that, if the supportive housing provider is doing care coordination, that agency should be compensated for its work. Feedback indicated that the agencies that are providing both supportive housing and care coordination reported having the most seamless experiences providing the necessary level of care.
- **Analyze Acuity Score Accuracy in Predicting Service Utilization** –Providers reported that acuity scores frequently did not always match tenants' service needs. The state should work with the providers to analyze in what situations the acuity scores over- or underestimated service need and recalibrate the algorithm.

NYS Office of Mental Health Recommendations

OMH awarded 700 units statewide; 438 beds in New York City and 262 units throughout the rest of the state. Eligibility criteria required that participants either be Health Home eligible or enrolled or be referred from a psychiatric hospital. If they were either, they were assumed to be a High Cost Medicaid User. Awardees received the scattered site rate of \$15,043 to support both the rent and housing based services. The supportive housing case manager was encouraged to work with the health home care coordinator to help coordinate services. The supportive housing provider took referrals from the partnering health home or through a ground up approach – shelters, hospitals etc. OMH took a very hands-on approach to working with both the supportive housing providers and health homes, convening a monthly joint meeting for a period of time to troubleshoot challenges in filling units. This assistance was extremely helpful in making the program a success.

OMH List of Recommendations

- **Increase Program Rates** - Providers universally felt that current reimbursement rates of just over \$15,000 for rent, operations and services are simply insufficient to meet clients' needs. NYC providers pointed out that studio apartments rent for \$1,200 and that the model of doubling up clients in two-bedroom apartments – which most down-state providers utilized -- is fraught with problems with both clinical and economic impacts. Providers also felt that in most cases, this population requires higher levels of care than can be supported by minimal services.
- **Allow Flexibility for Matching Housing Model to Clients Needs**- A number of providers felt the level of care MRT clients needed was more in line with that provided in the Community Residence/SRO model and, when possible, placed MRT clients in CR/SRO units and moved the more stable CR/SRO tenants to a scattered-site unit. Providers asked that, in future, this flexibility be maintained and backfilling be used where deemed clinically appropriate.
- **Add services to the intervention:** providers recommended that OMH add Mobile Clinics and Bridgers to help transition people into housing.
- **Allow Supportive Housing Providers to be Care Coordinators** – As discussed in the general recommendations, housing providers often complained that due to large caseloads, Health Home Care Coordinators were not as productive as had been hoped. That said, the providers that both offered both care coordination and case management under one roof said that having both functions in house was most useful in terms of coordinating care.
- **Provide Data Transparency** - Currently, a provider has no way of knowing if a client's inappropriate utilization of medical and psychiatric care is decreasing and consequently has no means of measuring success. NYS should share data and/or related benchmarks with providers so they can assess if they are meeting the defined goals of the program.

NYS Office of Alcoholism & Substance Abuse Services Recommendations

OASAS awarded 300 units throughout the state. To be eligible for the OASAS program, the person had to be Health Home eligible or enrolled and had to have been either in the emergency room five times over the past twelve months, had two inpatient stay's over the past twelve months, or a combination of four emergency visits and one inpatient stay over the past twelve months. Funding paid for rent and rent-associated expenses as well as housing-based services. The supportive housing provider took referrals from the Health Homes or through a ground up approach. Supportive housing providers were expected to find a person housing, place them into that housing and then provide housing based services. The care coordinator was responsible for coordinating the tenant's overall care. OASAS also took a very hands-on approach to helping troubleshoot program challenges and held monthly conference calls to address issues. Awardees felt this approach, along with the agency's ability to be flexible and accessible, attributed greatly to the program's success.

OASAS List of Recommendations

- **Increase Program Rates to Better Meet Population Need**- Providers reported that in most cases this population is high need and in need of higher levels of care than the current rate can support. Some NYC providers felt clients would be better served in a congregate setting with more enriched services. Other NYC providers thought an ACT team approach might better fit this population's needs. Recommendations for additional program services included addition of a peer specialist, a recovery coach and a medical professional.
- **Create a System to Check Eligibility and HCMU criteria** - Providers raved about OASAS' innovative but labor-intensive process for checking eligibility criteria. In essence, OASAS used its own staff to search Medicaid data to determine whether or not potential clients met utilization thresholds. Although OASAS was severely taxed by the process, providers reported that, from their perspective, the clarity and quick turnaround allowed them to spend time actually serving clients. Ideally, going forward, DOH would adequately fund this function and expand it to all MRT Supportive Housing programs.
- **Allow Supportive Housing Providers to Be Care Coordinators** - In downstate, many of the supportive housing providers were also performing the functions of the Health Home Care Coordinators because, as has been reported earlier, Care Coordinators had such high caseloads. In these cases, providers recommended that they receive reimbursement for these services.
- **Provide Data Transparency** - Currently, a provider has no way of knowing if a client's inappropriate use of medical services is decreasing and consequently has no way of measuring program success. NYS should share data and benchmarks with providers so they can assess if they are meeting the defined goals of the program.
- **Better Define Program Guidelines** - Program Guidelines should provide more detail on what services are to be provided. A suggestion was to look at the OMH guidelines and how they define the level of services to be provided.

- **Expand Program to Serve Families** – Providers requested that any future programs should also provide support for family units.

NYS Department of Health AIDS Institute Recommendations

The Department of Health AIDS Institute (DOH AI) created two different programs under MRT, one for NYC and another for the rest of state. In NYC, the agency provided funding to connect unstably housed individuals with AIDS who also had co-morbid conditions to housing – because the City provides housing to people with AIDS through the City’s HIV/AIDS Services Administration (HASA). Outside NYC, DOH AI provided funding for scattered site supportive housing for Health Home eligibles/enrollees that were both homeless and had AIDS. Downstate, DOH AI estimates the program has served some 500 people through these services; upstate they estimate just under 100 people were served. All awardees were allocated a \$130,000-\$140,000 contract.

DOH AI List of Recommendations

- **Develop System to Identify Eligible Client Before Engagement** – In NYC, the referral system prevented the provider from being able to verify program eligibility (HCMU) until after they had worked with the client for two months (once the first month’s billing had been approved) The system for verifying program eligibility should be changed so providers can verify whether or not a person is an HCMU and therefore eligible before engagement begins.
- **Provide Higher Program Rates**- Most providers indicated that this population needs a higher level of care than the current program structure and rate could support. In NYC, providers felt that a congregate setting may be a better fit for this population and also suggested allowing for a rent payee option. Providers in the rest of the state felt that the existing funding did provide for the right level of support in the housing, however suggested that the program should provide additional funding to support the cost of a security deposit and care package when the tenant is first placed into housing. In NYC, providers expressed a desire to see HASA benefits provide all entitlements – including full brokers’ fees and security deposits.
- **Compare Risk Assessment Scoring with Actual Need** – Providers reported that the current scoring methodology doesn’t consistently predict service need and suggests that AI compare the initial assessment with the actual need and adjust the tool as necessary..
- **Provide Data Transparency** - Currently, a provider has no way of knowing if a client’s inappropriate use of medical services is decreasing and consequently has no way of measuring program success. NYS should share data and benchmarks with providers so they can assess if they are meeting the defined goals of the program.
- **Improve Placement System from Nursing Homes** - In NYC, providers expressed a desire to try to place housing-needy individuals residing in nursing homes into housing but were experiencing roadblocks. Clarification as to how inreach is best accomplished, how tenants can access HASA benefits immediately upon release and determining what appropriate housing options exist for homeless nursing home residents would help providers house people exiting nursing homes.