Network Expansion Track Meeting

January 12, 2023

Introductions

- Please let us know who is here by sharing via chat:
  - Your Name
  - Organization

- It's also helpful to update your name in Zoom to include your name, organization, and state
  - To change how your name appears in Zoom:
    - Go to "Participants" list and select the icon with 3 dots to the right of your name
    - Select "Rename"
    - Enter your name and organization and select "Change"

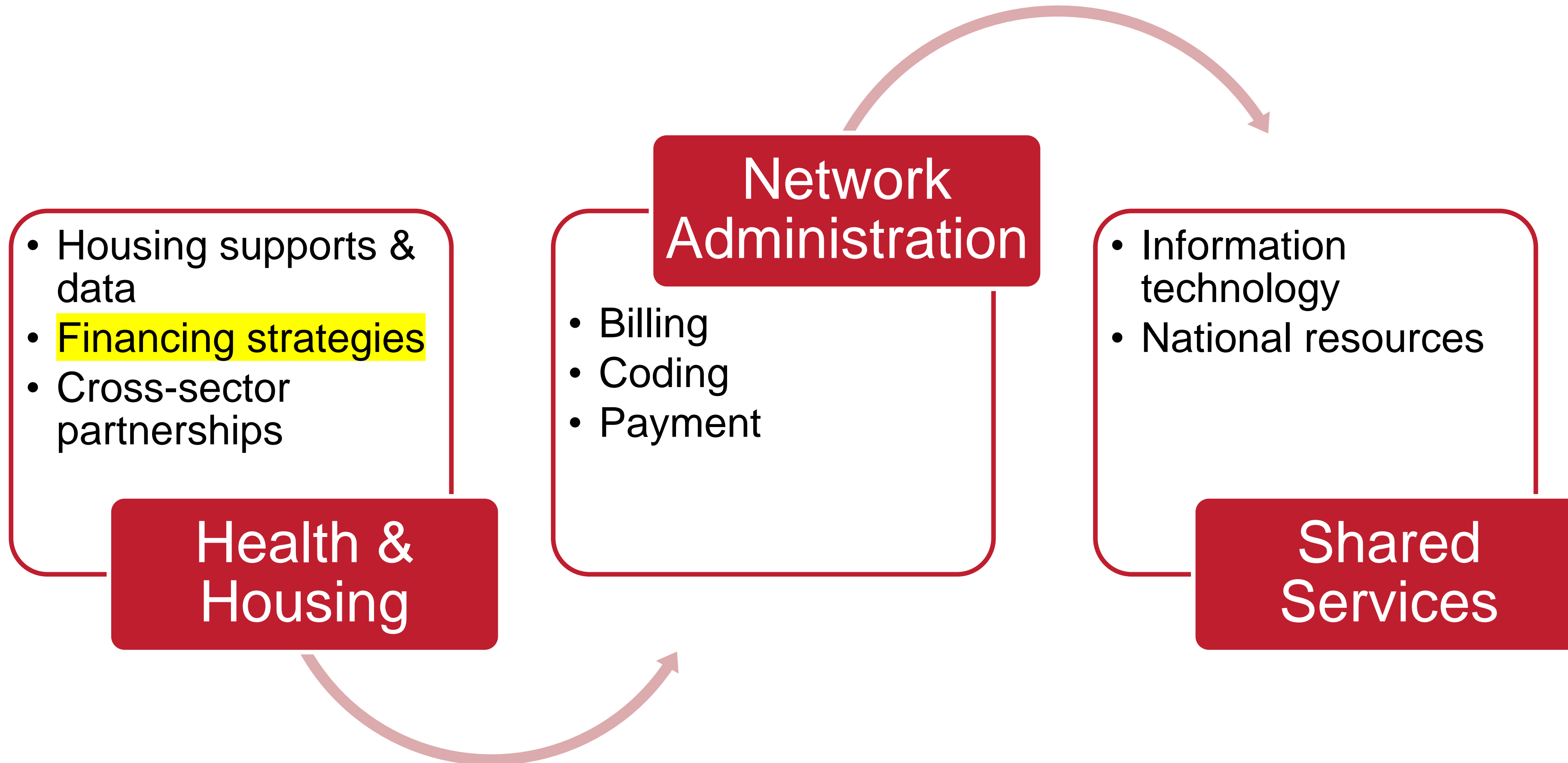
Agenda

- Welcome
- The Role of CCHs Addressing Housing Needs – A National Perspective
- Community Care Hubs' Working to Address Housing Needs – Panel Discussion
- Operationalizing Housing Supports – Washington, DC Example
- Open Discussion
- Closing

Logistics

- Recordings and meeting material
  - NLC meetings will be recorded and shared with NLC participants via email
  - Meeting material will be posted to the NLC technical assistance page
- Sound
  - Please keep yourself on mute unless speaking
- Use the Raise Hand function to engage
  - To raise your hand, click on the “Reactions” box and then click “Raise Hand.” You can also lower your hand by following the same process.
  - Please provide your name and organization when speaking
- Closed captioning
  - A live transcript of the meeting is available. To turn on closed captioning click on the upward arrow next to Live Transcript and select “Captions.” The Captions option may also be available under the icon labeled “More.”

Network Expansion Track

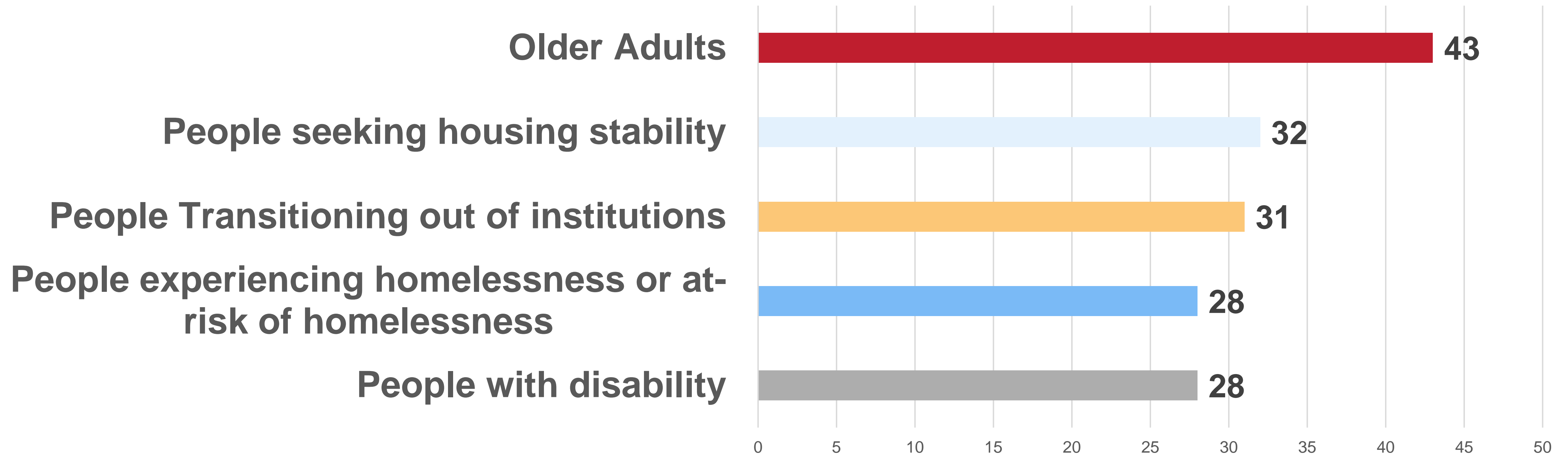


Dec | Jan | Feb | March | April | May | June | July | August

What we’ve heard from you:

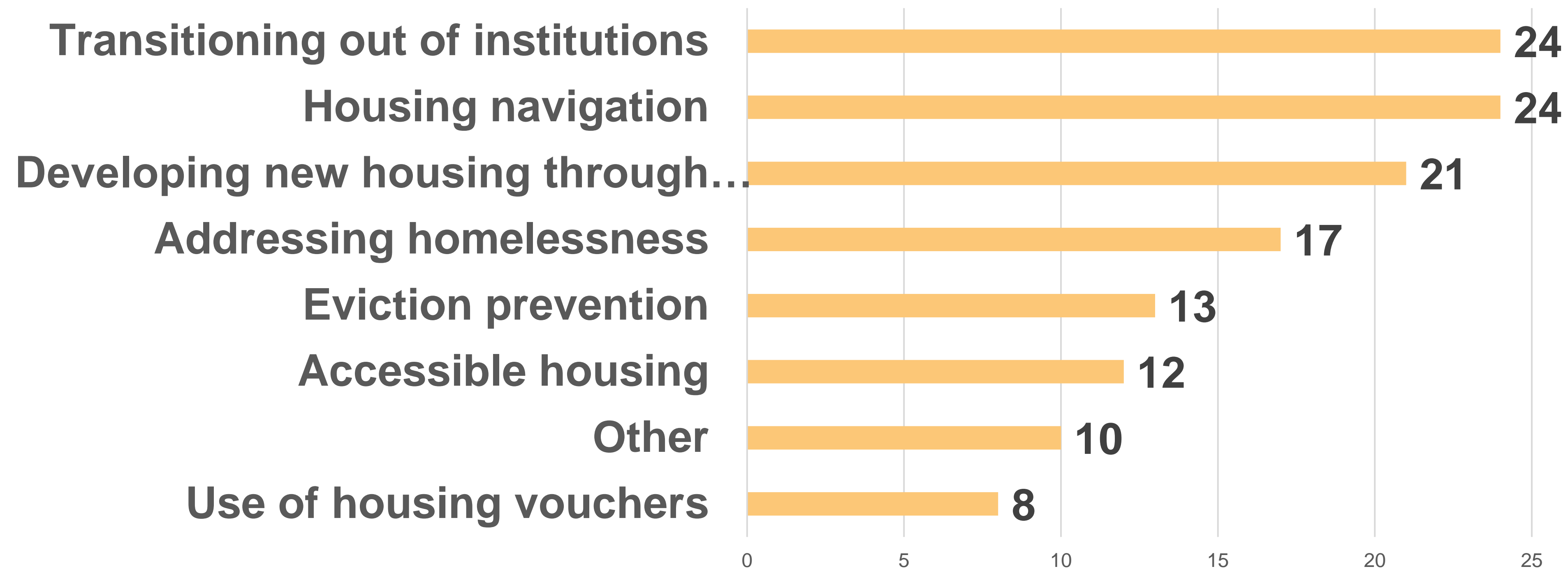
CCH HOUSING SUPPORTS & FOCUS AREAS

Target Populations for Housing Supports



Source: 12/8/22 Menti Poll

Priority Focus Areas

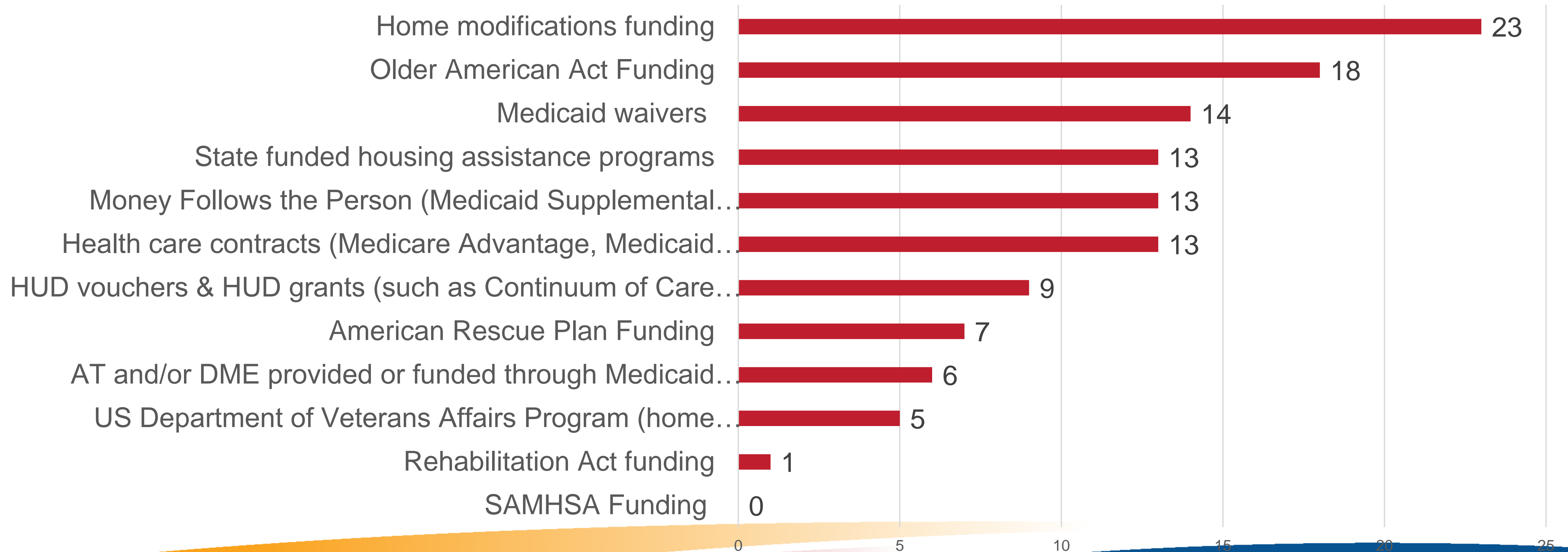


Other:

- Contracting opportunities to address housing
- Use of ARPA to address housing
- How to access funding streams for housing
- A deeper understanding of financing
- Funding sources for housing unstable
- CCH partnerships to address housing

Source: 12/8/22 Menti Poll

Funding Streams for Housing Services/Assistance



Source: 12/8/22 Menti Poll

The Role of CCHs in Addressing Housing Needs

A NATIONAL PERSPECTIVE

Housing Insecurity Impacting Hospital Admissions/ Discharges

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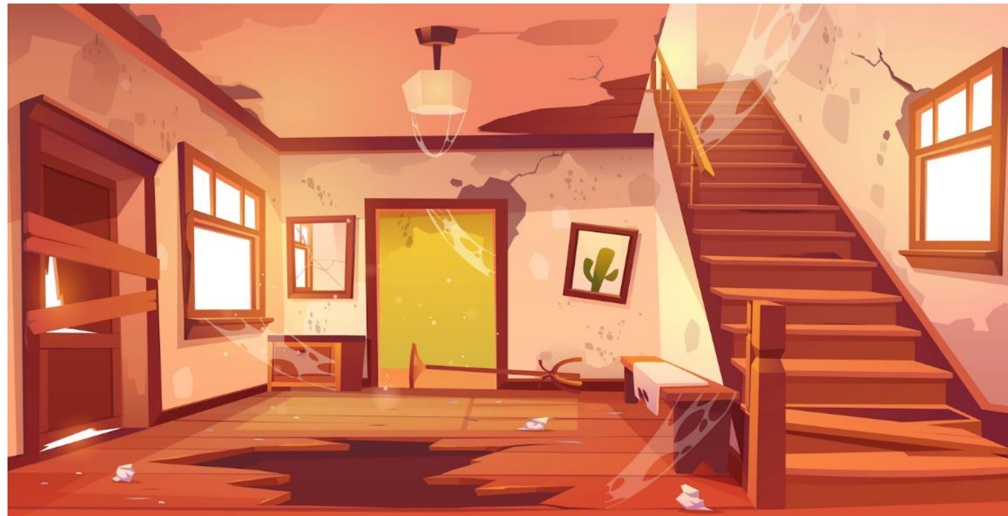
Chronic homelessness

Functional impairments limiting ability to maintain housing



Housing in disrepair and unsafe to return

Inability to pay rent/mortgage/taxes

January 2023 Implementation of Quality Metrics Requiring Screening for HRSNs

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Healthcare Actions to Implement New Quality Metrics Related to HRSNs

- Numerous reports of plans to rapidly expand HRSN screening to meet performance metrics beginning January 2023
  - NCQA
  - Joint Commission
  - CMS IPPS Rules
- Past experience with broad screening without defined interventions
  - Accountable Health Community Model

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CMS FY2023 Inpatient Prospective Payment System (IPPS) Rule

- Background:
- CMS pays acute care hospitals for inpatient stays under IPPS
- CMS sets base payment rates prospectively for inpatient stays based on the patient's diagnoses and any services performed
- A hospital receives a single payment for the services provided based on the payment classification assigned at discharge
  - MS-DRG (Medicare Severity Diagnosis-Related Groups)
  - Hospitals track length of stay closely, based on the MS-DRG admission criteria
  - Length of stays beyond the MS-DRG criteria = Loss of revenue for the hospital

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CMS FY2023 Inpatient Prospective Payment System (IPPS) Rule

- Key Rule Changes:
  - Hospital Commitment to Health Equity measure beginning with the CY 2023 reporting period/FY 2025 payment determination
  - Screening for Social Drivers of Health measure and Screen Positive Rate for Social Drivers of Health measure beginning with voluntary reporting in the CY 2023 reporting period and mandatory reporting beginning with the CY 2024 reporting period/FY 2026 payment determination
    - Housing Insecurity
    - Food Insecurity
    - Transportation Insecurity

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2023 HEDIS® SDOH Measure

- Effective **January 1, 2023**:
- The percentage of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing, and transportation needs, **and** received a corresponding intervention if they screened positive
- Percentage of members that screen positive and receive a corresponding intervention within 1 month
- Key SDOH categories:
  - Housing
  - Food
  - Transportation

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Joint Commission Health Care Disparities Requirements

- Effective **January 1, 2023**:
- Requirements:

1. Organization must designate an individual to lead activities to reduce health care disparities for the organization
2. Organization must assess for health-related social needs and provide information about community resources and support services
3. Organization must develop a written action plan to address at least one of the health care disparities prevalent in the population

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Evaluation of Accountable Health Communities (AHC) Model

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Accountable Health Communities Model (2017 – 2022)

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Model Overview

- The Accountable Health Community (AHC) Model tests whether connecting beneficiaries to community resources can improve health outcomes and reduce costs by screening and addressing health-related social needs (HRSNs).
- The Accountable Health Communities Model was based on emerging evidence that addressing health-related social needs through enhanced clinical-community linkages can improve health outcomes and reduce costs.
- Bridge organizations are required to screen all community-dwelling Medicare and Medicaid beneficiaries.
- **482,967 Medicare/Medicaid Beneficiaries** successfully screened using an evidence-based SDOH screening tool

Key Components

Accountable Health Community Model Findings

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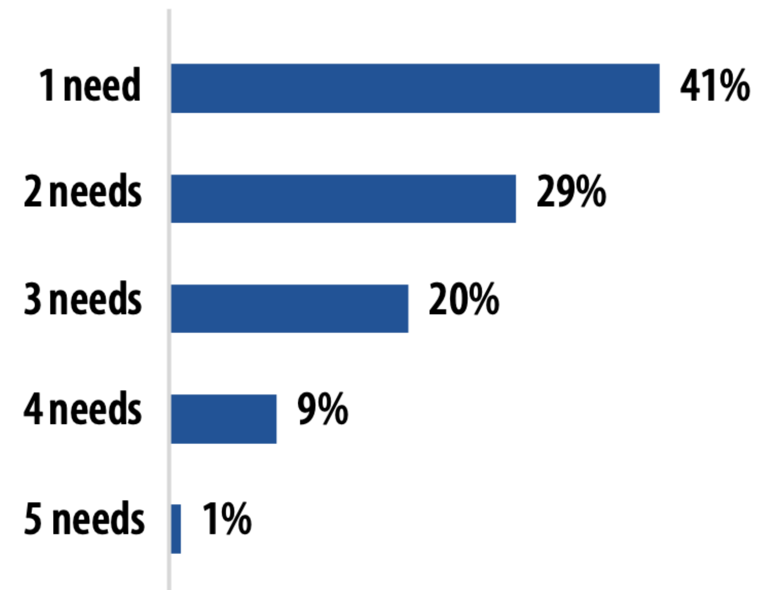
Evaluation

- More than half of navigation-eligible beneficiaries reported more than one core need.
- Food insecurity was the most commonly reported need (median prevalence of 69% across bridge organizations).
- Fully 74% of eligible beneficiaries accepted navigation, but only 14% of those who completed a full year of navigation had any HRSNs documented as resolved.
  - **Referrals without interventions**
- *Key Finding in Evaluation Report:

"The AHC Model is effectively identifying higher cost and utilization beneficiaries, and these beneficiaries are accepting navigation at higher rates than anticipated. However, **evidence of navigation effectiveness in resolving HRSNs was low** during early stages of implementation."

Significant Need Among the Population



Evaluation Report Link: https://innovation.cms.gov/data-and-reports/2020/ahc-first-eval-rpt-fg

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Community Care Hubs Working to Address Housing Needs

A PANEL DISCUSSION

CCH Panelists

- Joshua Gemerek – Senior Vice President, Housing, BayAging
- Lavinia Goto – Operations Manager, Oregon Wellness Network (OWN)
- Ester Sefilyan – Vice President, Network Services, Partners in Care Foundation

Panelist Discussion Questions

- Who are your housing partners (or who are you working to establish relationships with)? How did you establish those relationships?

- What does your housing services model look like? (services offered, populations reached, housing partners, etc.)? How is housing part of your CCH model?

- What existing financial resources do you access to address housing needs?
  - What new resources are you exploring to support these efforts?

- How did you build staff competencies to address housing needs? Did you train existing workforce, identify housing partners to include in your network, other means?

Operationalizing Housing Supports

WASHINGTON, DC EXAMPLE

Washington, DC Hospital Association Efforts to Address HRSNs Impacting Hospitals

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Priority Focus Areas

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- Housing insecurity that impacts the length of stay of hospital admissions
- Actions: Increased screening of housing insecurity in the ED and on admission
- Increased screening of mental illness and substance use disorder
- Key finding:
  - From 2016-2020, approximately 76% of fatal opioid overdoses were for adults between the ages of **40-69**
  - **Group with the largest increase in opioid overdoses in D.C.**
    - **1,200%** increase in opioid deaths for adults ages 70-79
    - **129%** increase in opioid deaths for adults ages 60-69

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Housing Insecurity Action Plan

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- Early screening and identification of persons with housing insecurity
- Target populations
  - Any person with a positive screen for housing insecurity
  - Housing insecurity is not the same as chronic homelessness
  - Dual eligible beneficiaries
  - Persons that reside in HUD-supported housing
  - Persons with a positive SUD screen with heavy focus on the population that has the greatest increase in opioid deaths (Ages 60-79)
- Actions: Coordinated "all of government" approach to address the impact of housing insecurity at DC hospitals

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Key Factors Impacting the Need to Preserve Existing Housing

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- Preservation of income required to maintain housing
  - SSI Temporary Institutionalization benefits for persons who are institutionalized for 90 days or less
  - Generally, if you enter a nursing home or hospital (or other medical facility) where Medicaid pays for more than half of the cost of your care, your Supplemental Security Income (SSI) benefit is limited to **$30 a month unless your length of stay is less than 90 days**
  - **SSA Rule: https://www.ssa.gov/ssi/spotlights/spot-temp-institution.htm**
- Preservation of public housing access when functional impairments are present
  - DC and Maryland have some of the highest rates of HUD-supported housing inspection failures
  - https://www.baltimoresun.com/news/investigations/bs-md-failed-housing-inspections-20190322-story.html
  - Repeated failed inspections can lead to eviction
  - Failed inspections related to functional impairments of residents is a pervasive problem
  - Functional impairments can lead to group home and assisted living facility evictions
    - Too sick for group home/ALF but not sick enough for nursing home admission = extended length of stay at hospital

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All of Government Approach

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- Medicaid MCOs will pay a financial incentive for HRSN screening and reporting along with payment for hospital transitions
- Coordinated effort between hospitals and Medicaid MCOs to intervene early when housing insecurity is identified
- Expedited processing of Medicaid Waiver and State Plan benefits to support early transitions back to existing housing, when functional impairments impact housing insecurity
- Combination of Adult Day Health Program, State Plan Skilled Nursing benefits, and Medicaid Waiver to provide a range of wraparound services as part of the discharge plan
- Coordination with the Department of Behavioral Health and the Department of Human Services to identify housing stock to support hospitalized persons with a history of homelessness and functional impairments
- Coordination team: Medicaid Ombudsman, Behavioral Health Ombudsman, Long-term Care Ombudsman pulls key resources to meet needs of hospitalized patients

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Social Care Navigation Initiated at Bedside and Coordinated with Ombudsman Team and MCO (if applicable)

LOW-BARRIER SHELTER	ASSISTED LIVING FACILITY
Family Shelter	Section 8 Voucher
Domestic Violence Shelter	HUD 811/202 housing
Rapid Rehousing	Medicaid Waiver housing voucher
Housing First	Money Follows the Person
Veteran HUD/VASH	VA home modification benefit
Short-term Housing Voucher	Medicaid waiver home modification benefit
Accessible Housing Program	CDBG home weatherization program
Single Room Occupancy (SRO) Program	CDBG heating assistance
Group Home	Mental health group home
Transitional Housing	ID/DD group home
Supportive Housing Program	Veteran group home
FCC Lifeline Cell Phone Program	FCC Affordable Connectivity Program

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Group Discussion

Discussion Questions

1. Tell us about your current or prospective housing partners. What aspects enabled success or posed challenges to these partnerships?
2. What financial resources are you currently deploying and/or exploring to address housing needs?
3. What are 1-2 actions your CCH can take to address housing needs in your community?

Resources

- CMS press release on hospital inpatient prospective payment system (IPPS)
- Kaiser Family Foundation: 1115 Waiver Watch – Approvals Address Health-Related Social Needs
- Additional information on new HEDIS Social Need Screening and Intervention (SNS) measure
- HSRC BayAging Case Study
- Spotlight on SSI Temporary Institutionalization Benefits for Persons Who are Institutionalized 90 Days or Less – 2022 Edition

Upcoming Meetings & Events

- Peer Group Dialogue Meeting – January 26, 2023, 2-3pm ET
  - Bring your questions, resources, and challenges related to developing, implementing and funding housing assistance services
- Network Expansion Health and Housing Session #3 - February 9, 2023, 2-3pm ET
  - Theme: Cross-Sector Partnerships

Save the Date: The 2023 USAging Annual Conference and Tradeshow is scheduled for July 16-19, 2023, in Salt Lake City. ACL will be hosting a pre-conference intensive for the NLC on **Saturday, July 15, 2023**. More details to come. **Please complete this brief questionnaire to let us know if you plan to attend: https://www.surveymonkey.com/r/W728NS8**

Thank you!
Please contact
CommunityCareHubs@acl.hhs.gov
with any questions.

ACL
Administration for Community Living