Center for Health Care Strategies
Better care where it's needed most

In lieu of Services Technical Assistance

December 3, 2021

Diana Crumley, Senior Program Officer, CHCS

Made possible by the Episcopal Health Foundation

Center for Health Care Strategies

Dedicated to strengthening the U.S. health care system to ensure better, more equitable outcomes, particularly for people served by Medicaid.

Together with our partners, our work advances:

- **Effective models for prevention and care delivery** that harness the field's best thinking and practices to meet critical needs.
- **Efficient solutions for policies and programs** that extend the finite resources available to improve the delivery of vital services and ensure that payment is tied to value.
- **Equitable outcomes for people** that improve the overall wellbeing of populations facing the greatest needs and health disparities.

Center for Health Care Strategies

CHCS Approach to Work

We partner with Medicaid stakeholders — including state and federal agencies, managed care plans, providers, community-based organizations and consumers — to promote innovations in health care delivery where they are needed most.

Through our work, we:


Identify and advance best practices


Drive policy improvements with evidence and insights


Develop the capacity and expertise of health care leaders


Provide practical training, technical assistance, and tools


Spread success by connecting peers and experts across sectors

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What are *in lieu of* services?

State Medicaid Levers to Address Health-Related Social Needs

Benefit Design

- Medicaid state plan amendments

-1915(c) waivers

-1115 demonstration projects

-1915(b)(3) waivers

-CHIP Health Services Initiatives

Delivery System

-Medicaid managed care organizations

-Medicaid accountable care organizations

-Value-based payment (VBP) initiatives

Program Partnerships

-Fast Track Enrollment

-Targeted Enrollment Outreach

-Braiding Medicaid funding with other program funds

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In lieu of Services (ILOS): Federal Rule & Example

An MCO may cover, for enrollees, services or settings that are **in lieu of services or settings** covered under the State plan as follows:

- The State determines that the alternative service or setting is a **medically appropriate and cost-effective substitute** for the covered service or setting under the State plan
- The enrollee is not required by the MCO, PIHP, or PAHP to use the alternative service or setting
- The approved in lieu of services are **authorized and identified in the MCO, PIHP, or PAHP contract**, and will be offered to enrollees **at the option** of the MCO, PIHP, or PAHP

Example: "in-home prenatal visits for at-risk pregnant beneficiaries as an alternative to a traditional office visit"

Cost & Utilization of Services: Developing MCO Capitation Rates

- **Projected Benefit Costs** (a.k.a., "Benefit Load")
  - → State plan services
  - → *In lieu of* services (some exceptions) ✓
- **Projected Non-Benefit Costs** (a.k.a., "Non-Benefit Load")
  - → Care coordination and care management
  - → Other material non-benefit costs (e.g., other quality improvement costs)
  - → Administrative costs

✘ The cost of **value-added services** cannot be included when determining payment rates.

Pre-approved ILOS: Texas (Behavioral Health)

- **Current – settings in lieu of an acute care inpatient hospital setting**
  - → Freestanding psychiatric hospital
  - → Substance use disorder treatment services in a chemical dependency treatment facility
- **Phase one – services in lieu of inpatient services (2021)**
  - → Coordinated specialty care
  - → Crisis respite
  - → Crisis stabilization units
  - → Extended observation units
  - → Partial hospitalization
  - → Intensive outpatient program
- **Phase two – services in lieu of outpatient services (2022)**
  - → Cognitive rehabilitation
  - → Multisystemic therapy
  - → Functional family therapy

Pre-approved ILOS: California

- Services tailored to individuals experiencing homelessness
  - → Housing Transition Navigation Services

  Housing Deposits
  - → Housing Tenancy and Sustaining Services
  - → Short-Term Post-Hospitalization Housing
  - → Recuperative Care (Medical Respite)
- Medically Supportive Food/Meals/Medically Tailored Meals
- Services tailored to individuals who need assistance with activities of daily living
  - → Respite Services
  - → Day Habilitation Programs
  - → Community Transition Services
  - → Nursing Facility Transition
  - → Personal Care and Homemaker Services
  - → Environmental Accessibility Adaptations (Home Modifications)
- Asthma Remediation

Pre-approved ILOS: Kansas

- Waiver & Waiver-like Services
  - → Adults and children, to avoid a higher level of care
  - → Members on waiting lists for Home and Community-based Services (HCBS) Waivers
  - → Members on HCBS waivers that do not have those services in their assigned waiver
- Institutional Transition Assistance Funding
- Medical Nutrition Therapy
- Diabetes Self-Management Training (DSMT)
- Parent Management Training-Oregon Model

State Decision Points: Startup

- Should the state pre-approve ILOS?
- Should the state create a process for MCOs to submit ILOS for approval?
- How will the state or MCOs engage communities to determine appropriate ILOS? Who will be consulted?
- Which services should be approved?
  - → Is the service a "cost-effective and medically appropriate substitute," and what evidence will be considered?
- How will approval of the services be formalized in contracts?

State Decision Points: Implementation

- Developing MCO reporting requirements
- Using data to develop rates
- Supporting partnerships between MCOs & CBOs
  - → Credentialing
  - → Rate guidance
  - → Model contracts
- Member protections & continuity of care (length of ILOS elections)
- Capacity building
- Technical assistance

Consider existing Texas programs and research

- Within Medicaid:
  - → Many HCBS waivers and programs!
    - E.g., Home and Community-Based Services – Adult Mental Health (HCBS-AMH), with a potential upcoming evaluation
  - → Many existing and emerging MCO programs and pilots (e.g., asthma, housing, food)!
- Outside Medicaid
  - → Supportive housing models (for individuals experiencing homelessness)
  - → Food prescriptions
  - → Home-delivered meals
  - → Social isolation interventions

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Better care where it's needed most

Exploring Asthma Remediation

January 25, 2022

Made possible by the Episcopal Health Foundation

Green & Healthy Homes Initiative®

Home-Based Asthma Programs: Structure and Evidence

Briefing for The Texas Value-Based Payment & Quality Improvement Advisory Committee

January 25, 2022

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Green & Healthy Homes Initiative®

Addressing the Social Determinants of Health and Racial Equity Through Healthy Housing

Notable Milestones

- Partnership with ProMedica on $100M initiative to address SDOH through healthy housing in seven cities
- Designed nation's largest hospital community benefit grant for healthy housing with Lancaster General Health ($50M)
- CMS cited GHHI-Amerigroup Program as national model
- Launched nation's first outcomes-based financing project with Medicaid MCO for NYC asthma program ($4.75M)
- Designed $10M VBP asthma project w/NYSERDA & NYSDOH
- Strategic partner with state of MD on CHIP Health Services Initiative for asthma & lead services
- Publication and years of advocacy for 'in lieu of' services helped get healthy homes services as ILOS in CA
- Connected 30+ asthma programs to healthcare via program development support; 8 led to funding contracts so far
- Published EPA-sponsored Recommendations for Evaluation Metrics for Asthma Home Visiting Programs in 2019

Components of Home-based Asthma Programs and Considerations

Outreach to Specific Target Population

- Recommend defining target outcomes and referral sources, then align target pop.
- Can define high-risk based on insurance, utilization, Rx usage, etc.
- Identification/outreach may depend on data access, possible lags

Home Visiting and Case Management

- Typically, 2-3 visits to assess needs, provide asthma self-mgmt. education and supplies
- Performed by CHWs (or equivalent), nurses, and/or care managers
- Great opportunity to do other SDOH screening

Environmental Trigger Remediation

- In-depth assessment of home environment
- Core services: integrated pest mgmt., mold, venting, carpet removal/replacement
- Performed by trained specialists and contractors

Monitoring and Follow-Up

- At least 3 follow-up calls to check in, reinforce education, and re-assess needs
- Additional survey data collected on these calls for evaluation

Additional key considerations

- Some programs do not include environmental trigger remediation, but (1) there is evidence supporting its positive effect on health outcomes and (2) it is a critical factor in health equity—home conditions, which are worse in low-income communities, impact a wide range of health outcomes beyond those related to asthma.
- Per-enrollee program cost range without env. remediation: $700-$2,500; with env. remediation: $3,500-$5,500.
- These programs can reside fully or partially in MCOs, providers, community-based organizations, or government agencies.

National Guidelines Call for a Comprehensive Home-based Intervention, based on systematic reviews of evidence.

Key findings from CDC Task Force systematic review:

- **ROI of $5.3 - $14.0 for each $1 invested**
- -0.57 avg. decrease in median number of acute care visits per year
- -21 avg. decrease in symptom days per year
- -12.3 avg. decrease in school absences per year

CDC
Centers for Disease Control and Prevention

"**Home-based, multi-trigger, multicomponent interventions with an environmental focus**" are conclusively effective for children, but more evidence is needed to determine effectiveness for adults.

NIH EPR-3 Guidelines also call for **assessment**, **education**, and **control of environmental factors**.

NIH
National Institutes of Health

Rigorous Studies Assessing Impact on Healthcare Costs

GHHI Healthy Homes Technical Study (Baltimore) – independent study of impact on children's Medicaid costs between (1) home visiting model, (2) full model with env. remediation, and (3) matched comparison group.

- Home visiting model reduced Medicaid total cost of care by **$530 (7%) in 12 months, with ROI of 80%**
- Full model reduced Medicaid total cost of care by **$2,959 (35%) in 12 months, with ROI of 58%**

Le Bonheur CHAMP program NORC study (Memphis) – independent multi-year study of impact on children's Medicaid costs between (1) clinic-home visiting hybrid model participants, and (2) matched comparison group.

- Average Medicaid total cost of care **savings of $2,207 per child per year over 2.3 years**
- Medicaid cost of care **reduction totaled $2.51 million for 497 patients**

Boston Children's Hospital Community Asthma Initiative (CAI) – 5-year cost-benefit analysis of impact on children's medical costs between (1) CHW home visiting program participants and (2) matched comparison group.

- Program cost reduction vs. comparison: Y1-$1,216, Y2-$1,220, Y3-$1,312, Y4-$1,123, Y5-$997
- **Net benefit over 5 years was $587,398, with ROI of 191% for 268 patients**

Sources: Bhaumik, U., et. al. (2017). Boston children's hospital community asthma initiative: Five-year cost analyses of a home visiting program. Journal of Asthma, 54(2), 134-142.
Moiduddin, A (June 2017). Third Annual Report Addendum: HCIA Disease-Specific Evaluation. NORC at the University of Chicago. P. 17-18.

Green & Healthy Homes Initiative®

Thank you!

Q&A

www.ghhi.org

HealthyHousing

Appendix – Links to Notable Studies of Home-based Asthma Programs

National, A. E., & Prevention, P. (2007). Expert Panel Report 3 (EPR-3): Guidelines for the Diagnosis and Management of Asthma-Summary Report 2007. The Journal of allergy and clinical immunology, 120(5 Suppl), S94. Retrieved from https://www.jacionline.org/article/S0091-6749(07)01823-4/fulltext

Nurmagambetov, T. A., Barnett, S. B. L., Jacob, V., Chattopadhyay, S. K., Hopkins, D. P., Crocker, D. D., ... & Task Force on Community Preventive Services. (2011). Economic value of home-based, multi-trigger, multicomponent interventions with an environmental focus for reducing asthma morbidity: a Community Guide systematic review. American Journal of Preventive Medicine, 41(2), S33-S47.
http://www.asthmacommunitynetwork.org/system/files/Economic%20Values%20of%20Asthma%20Interventions.pdf

Crocker, D. D., Kinyota, S., Dumitru, G. G., Ligon, C. B., Herman, E. J., Ferdinands, J. M., ... & Task Force on Community Preventive Services. (2011). Effectiveness of home-based, multi-trigger, multicomponent interventions with an environmental focus for reducing asthma morbidity: a community guide systematic review. American journal of preventive medicine, 41(2), S5-S32. https://www.thecommunityguide.org/sites/default/files/publications/Asthma-AJPM-evrev-homebased.pdf

Ganesh, B., Skopec, C. P. S. L., & Zhu, J. (2017). The Relationship between Housing and Asthma among School-Age Children. Retrieved from http://www.nchph.org/wp-content/uploads/2017/10/UI-2017-Housing-and-Asthma-among-School-Age-Children-AHS-2015-1.pdf

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https://pediatrics.aappublications.org/content/pediatrics/138/5/e20162589.full.pdf

Federman, A. D., O'Conor, R., Mindlis, I., Hoy-Rosas, J., Hauser, D., Lurio, J., ... & Wisnivesky, J. P. (2019). Effect of a Self-management Support Intervention on Asthma Outcomes in Older Adults: The SAMBA Study Randomized Clinical Trial. JAMA internal medicine, 179(8), 1113-1121.
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Kercsmar, C. M., Beck, A. F., Sauers-Ford, H., Simmons, J., Wiener, B., Crosby, L., ... & Mansour, M. (2017). Association of an asthma improvement collaborative with health care utilization in Medicaid-insured pediatric patients in an urban community. JAMA pediatrics, 171(11), 1072-1080.
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Woods, E. R. (2016). Community asthma initiative to improve health outcomes and reduce disparities among children with asthma. MMWR supplements, 65.
https://www.cdc.gov/mmwr/volumes/65/su/su6501a4.htm

Appendix (cont.) – Links to Notable Studies of Home-based Asthma Programs

Bhaumik, U., Sommer, S. J., Giller-Leinwohl, J., Norris, K., Tsopelas, L., Nethersole, S., & Woods, E. R. (2017). Boston children's hospital community asthma initiative: Five-year cost analyses of a home visiting program. Journal of Asthma, 54(2), 134-142. https://www.tandfonline.com/doi/pdf/10.1080/02770903.2016.1201837?needAccess=true

Turcotte, D. A., Alker, H., Chaves, E., Gore, R., & Woskie, S. (2014). Healthy homes: in-home environmental asthma intervention in a diverse urban community. American journal of public health, 104(4), 665-671. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4025713/

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Krieger, J., Song, L., & Philby, M. (2015). Community health worker home visits for adults with uncontrolled asthma: the HomeBASE Trial randomized clinical trial. JAMA internal medicine, 175(1), 109-117. https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1939375

Campbell, J. D., Brooks, M., Hosokawa, P., Robinson, J., Song, L., & Krieger, J. (2015). Community health worker home visits for Medicaid-enrolled children with asthma: effects on asthma outcomes and costs. American Journal of Public Health, 105(11), 2366-2372. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4605150/

Margellos-Anast, H., Gutierrez, M. A., & Whitman, S. (2012). Improving asthma management among African-American children via a community health worker model: findings from a Chicago-based pilot intervention. Journal of Asthma, 49(4), 380-389. https://www.tandfonline.com/doi/pdf/10.3109/02770903.2012.660295?needAccess=true

Gutierrez Kapheim, M., Ramsay, J., Schwindt, T., Hunt, B. R., & Margellos-Anast, H. (2015). Utilizing the Community Health Worker Model to communicate strategies for asthma self-management and self-advocacy among public housing residents. Journal of Communication in Healthcare, 8(2), 95-105. https://www.tandfonline.com/doi/pdf/10.1179/1753807615Y.0000000011?needAccess=true

UnitedHealthcare Community Plan of Texas

Asthma Remediation

HHSC Quality Committee Presentation

January 25, 2022

United Healthcare®

Overview

1. **UHC Commitment**

2. **Collaborations**
   - Green and Healthy Homes Initiative (GHHI)
   - Texas Asthma Control Collaborative with Texas Department of State Health (DSHS)

3. **Innovative Pilots**
   - Airwaze

4. **SDOH Framework**

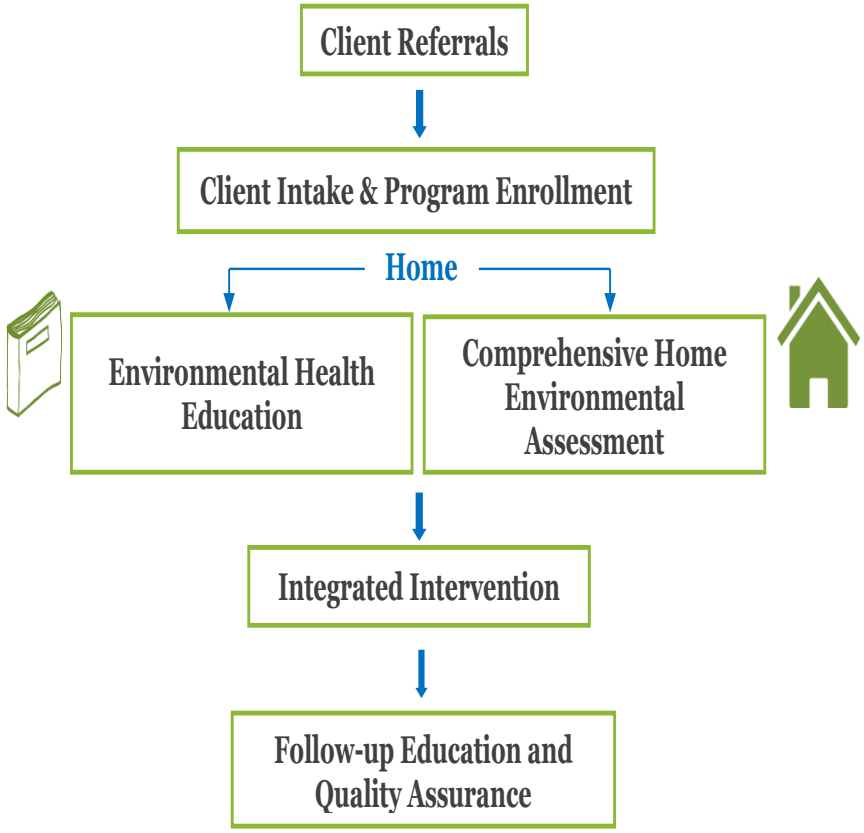
5. **Provider Alignment and Partnerships**

UHC Commitment

UHC is committed to developing innovative intervention programs that aim to significantly reduce healthcare utilization and cost of care for our Medicaid members, and ultimately lead to improved health and quality of life.

UHC & GHHI Collaboration

- Member identification (UHC)
- Member outreach (UHC)
- Clinical Intervention (Provider/Home Remediation)
- Collaboration & Evaluation (UHC/Provider)



Collaborations

Texas Asthma Control Collaborative
Texas Department of State Health (DSHS)

Participants

- DSHS
- HHS
- MCOs

UHC Interventions

- Increased Telehealth initiatives
- Increased Community Referrals/Aunt Bertha

Criteria

- Medicaid STAR members
- J Code Diagnosis

Impacts

- Improves access to care
- Medication adherence
- Education
- Reduced/inpatient visits

Innovative Pilot
Airwaze

Gives members with persistent asthma and COPD, as well as their parents/caregivers, tools to improve disease self-management and medication adherence, leading to improved health outcomes.

Objectives

- Improve medication adherence through the use of "smart" inhaler attachments
- Reduce asthma and COPD-related ER visits and hospitalizations
- Improve HEDIS AMR/PDC quality measures

How it Works

- Members are given "smart" inhaler sensors that attach to their rescue and controller inhalers
- Sensors automatically track inhaler usage and connect to mobile application
- Mobile application provides medication reminders, asthma and COPD-management tools, and guidance tailored to patient needs

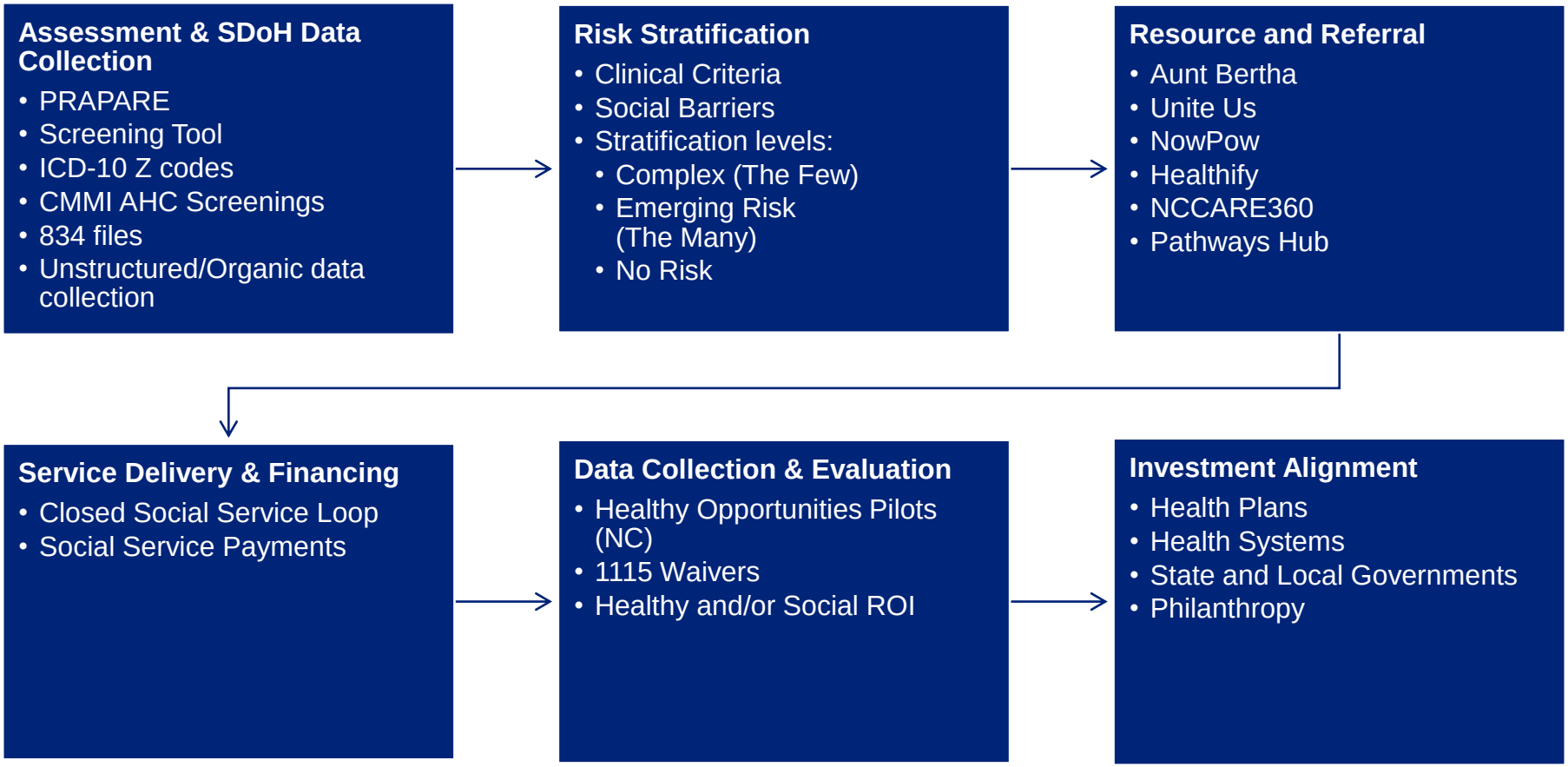
Participating Health Plans

- Launched: MS, PA, TX
- In Development: NE, MO, WA

Vendor Results

- 1.8 – 2.5x increased medication adherence
- Pediatric Medicaid patients show 55% reduction in uncontrolled asthma over 6-month period

SDoH Framework Overview



Provider Alignment and Partnerships

***Goal**: Develop and implement provider partnerships and health system engagement opportunities focused on the **integration of health equity and SDoH strategies** into the clinical workflow.*

Data Sharing

Share SDoH data through expanded provider screenings with actionable and bidirectional data flow

Value Based Contracting

Drive SDoH collaboration opportunities and deliver better clinical outcomes

Coding Standardization

Promote the adoption & expansion of ICD-10 SDoH industry standard coding

Health Equity

Implement health equity driven prioritization and outreach strategies using provider screening data

CITY OF SAN ANTONIO
METROPOLITAN HEALTH DISTRICT

SA Kids B.R.E.A.T.H.E.

Building Relationships, Effective ASTHMA Teaching in Home Environments

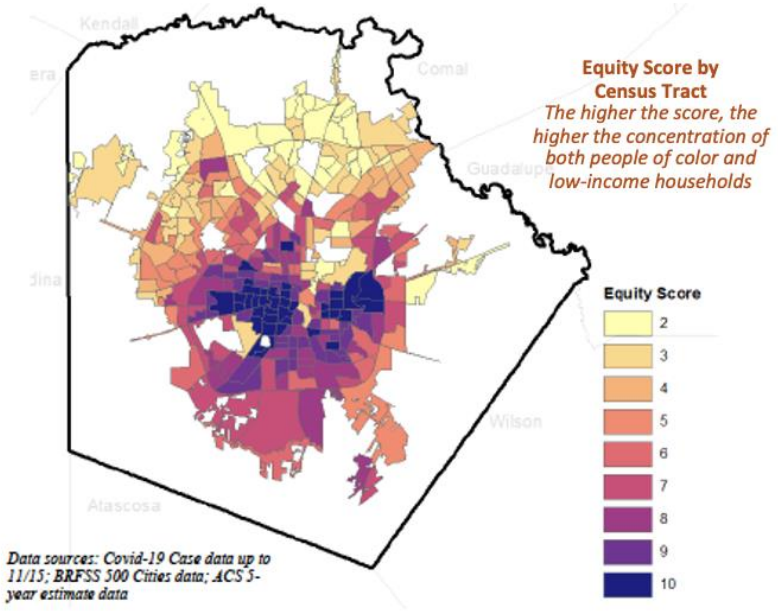
San Antonio's
Asthma Home Education Program

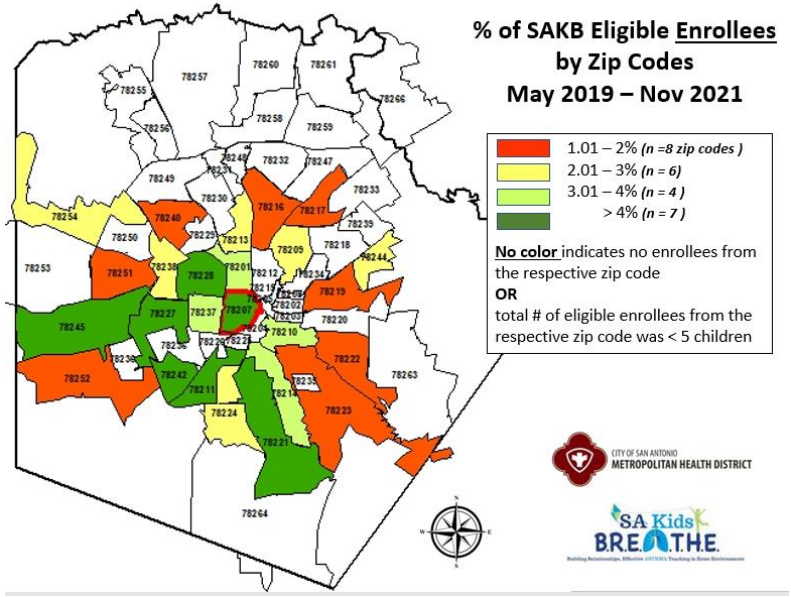
Mandie Tibball Svatek, MD, SAKB Medical Advisor
Cara Hausler, MPH, SAKB Program Manager
1/25/2022

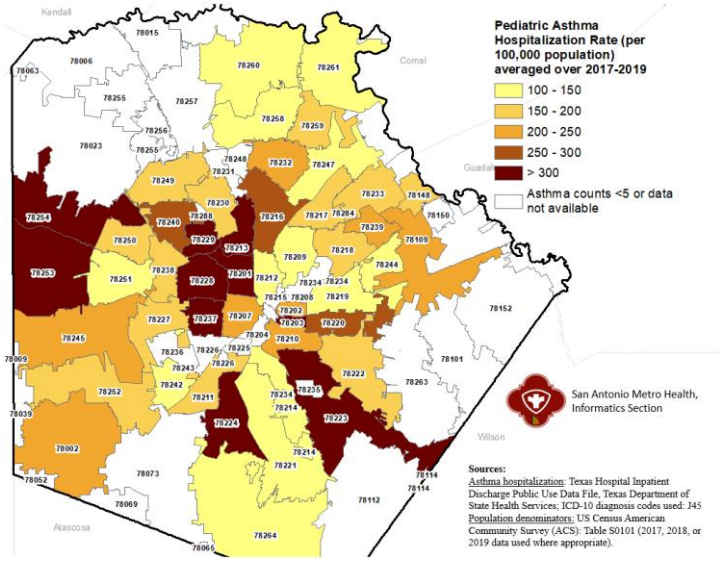
SA Kids BREATHE (SAKB) Timeline

Time	Action
Jan.-September 2018	South Texas Asthma Coalition advocates to City of San Antonio for **SA Kids BREATHE** (SAKB) to be formed under San Antonio Metropolitan Health Department with City Budget Amendment
Oct. 2018 – ongoing	**SAKB Advisory Council** for new asthma program formed in October; council continues to meet monthly
Jan 2019 – March 2021	**Green and Healthy Homes Initiative (Technical Assistance)** Business Development – January – September 2019 Asthma Reimbursement Support – February 2020 – March 2021
May 2019	SAKB Services Began
Fall 2019-Mar. 2020	Discussions with 2 MCOs for a direct contract
February 2020	Texas DSHS EXHALE grant awarded; provides support to SAKB and works on policy
March–Aug. '20	<SAKB services reduced and then delayed for COVID-19 Initial Response>
Summer 2020	BAA signed with a local health plan, Community First, allowing direct referrals and communication
February 2021 - ongoing	SAKB and Pathways HUB discussions began Pilot in development for Community First members

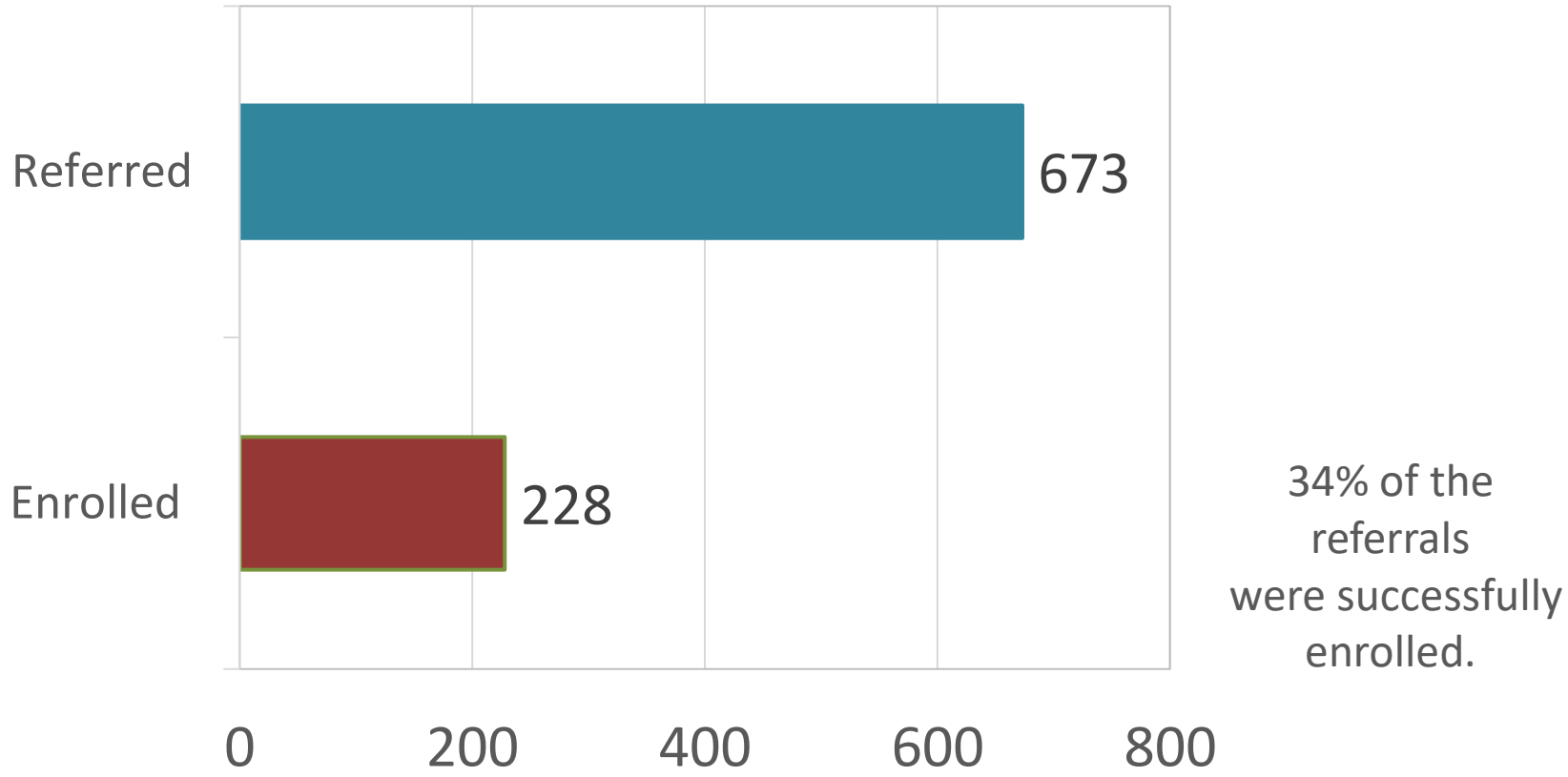
Comparison of **Equity Score** (11/2015), **SAKB Enrollees** (5/2019-11/2021), and **Pediatric Asthma Hospitalization Rate** (2017-2019) for Bexar County, Texas







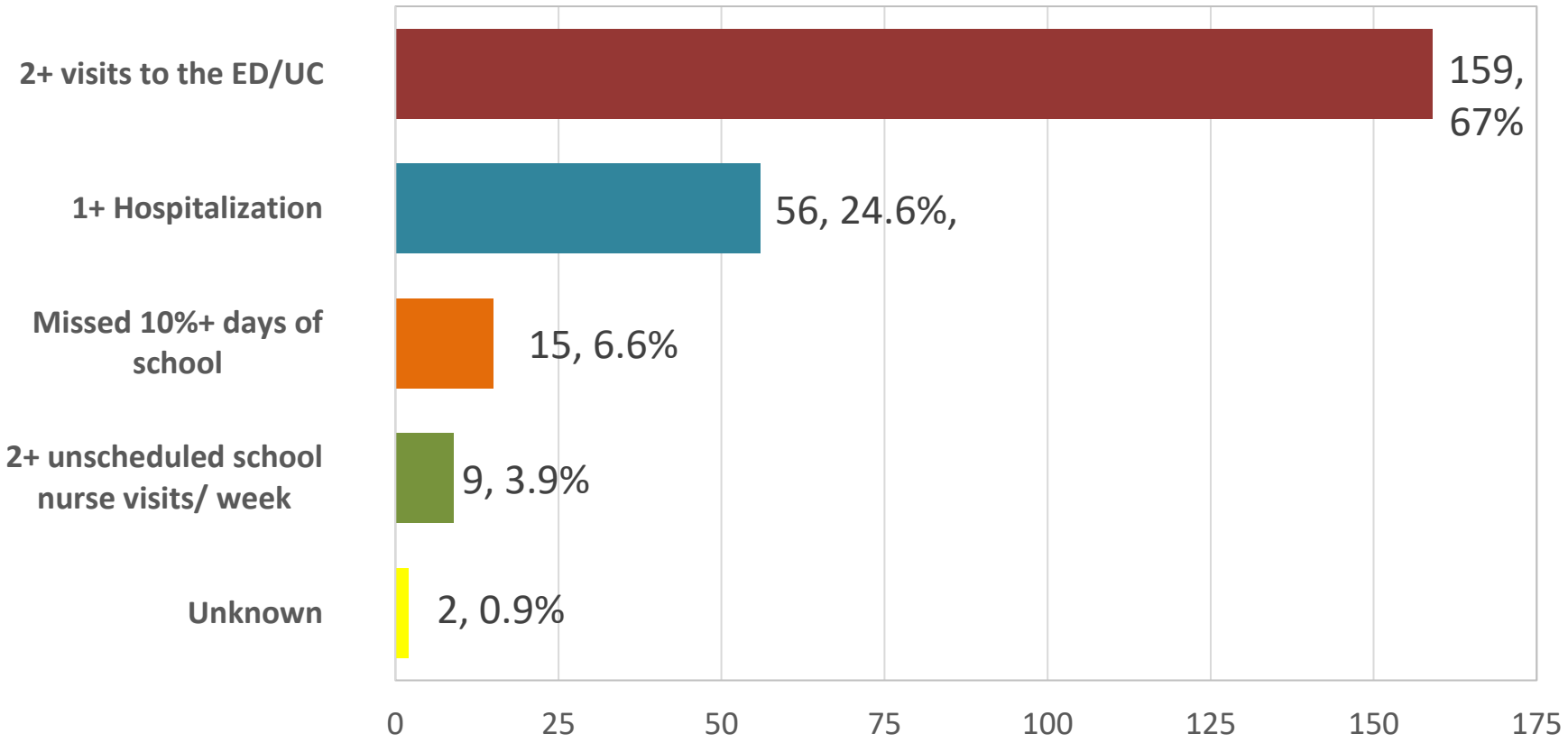
Referrals Received by SA Kids BREATHE Program 05/01/2019 - 08/26/2021



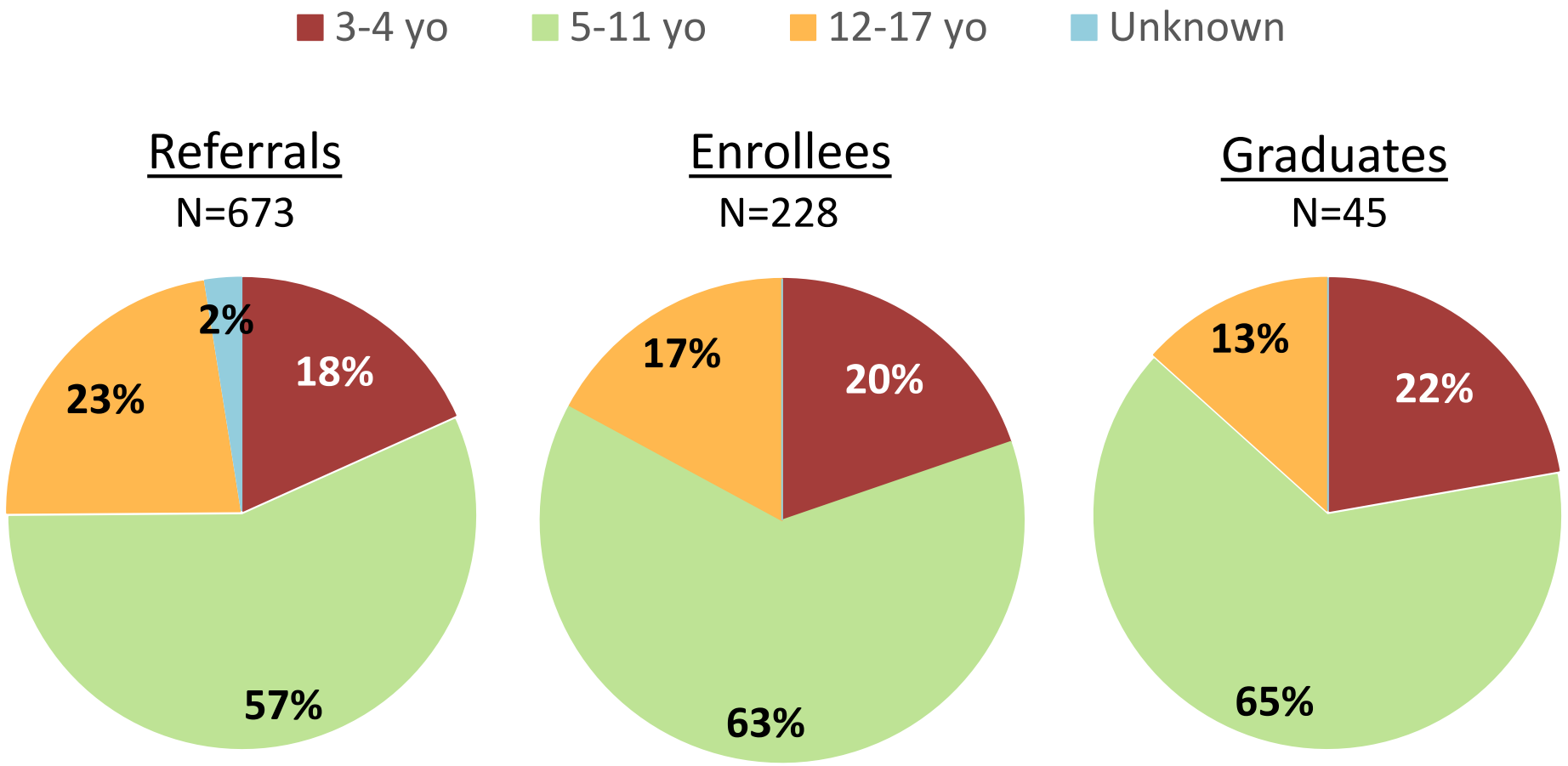
34% of the referrals were successfully enrolled.

Eligibility Criteria in Enrollees

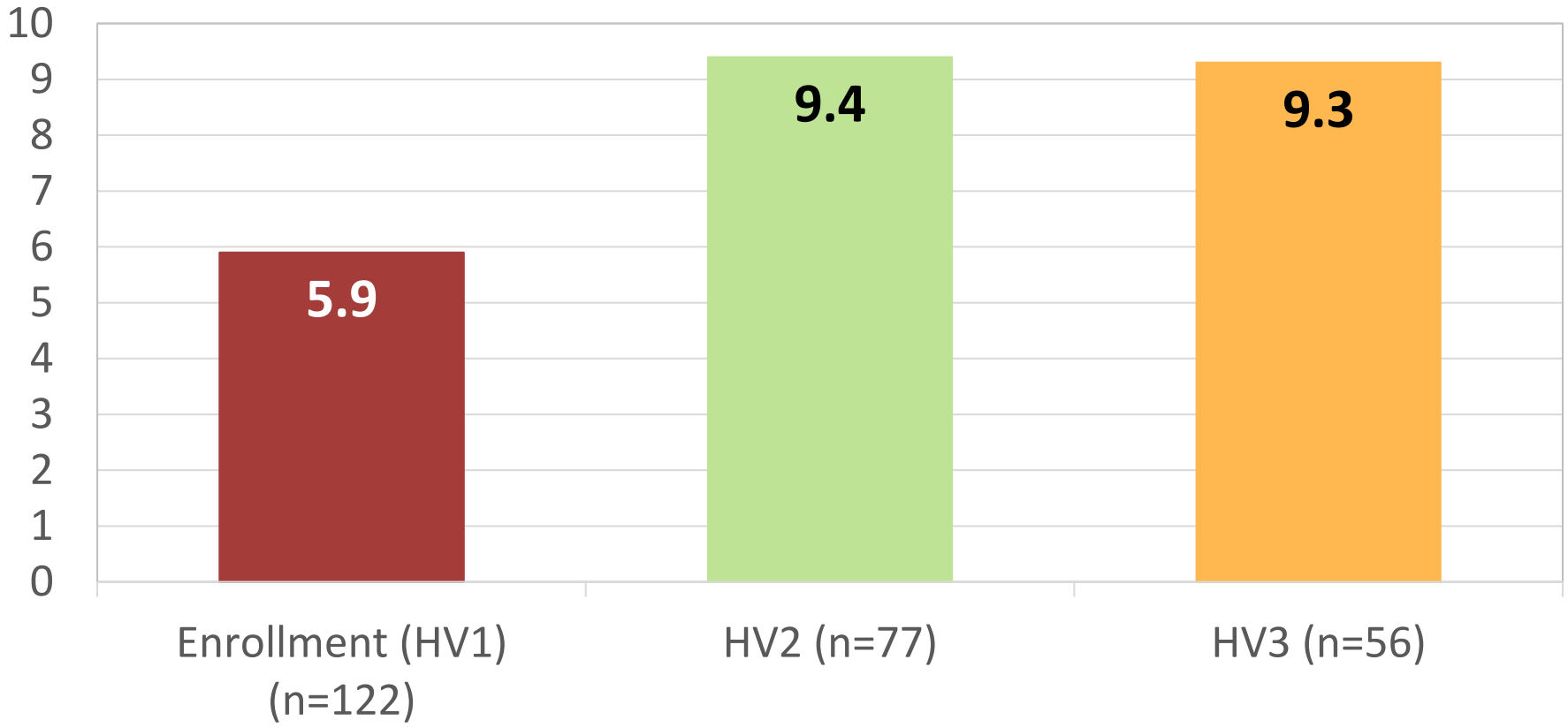
n = 228



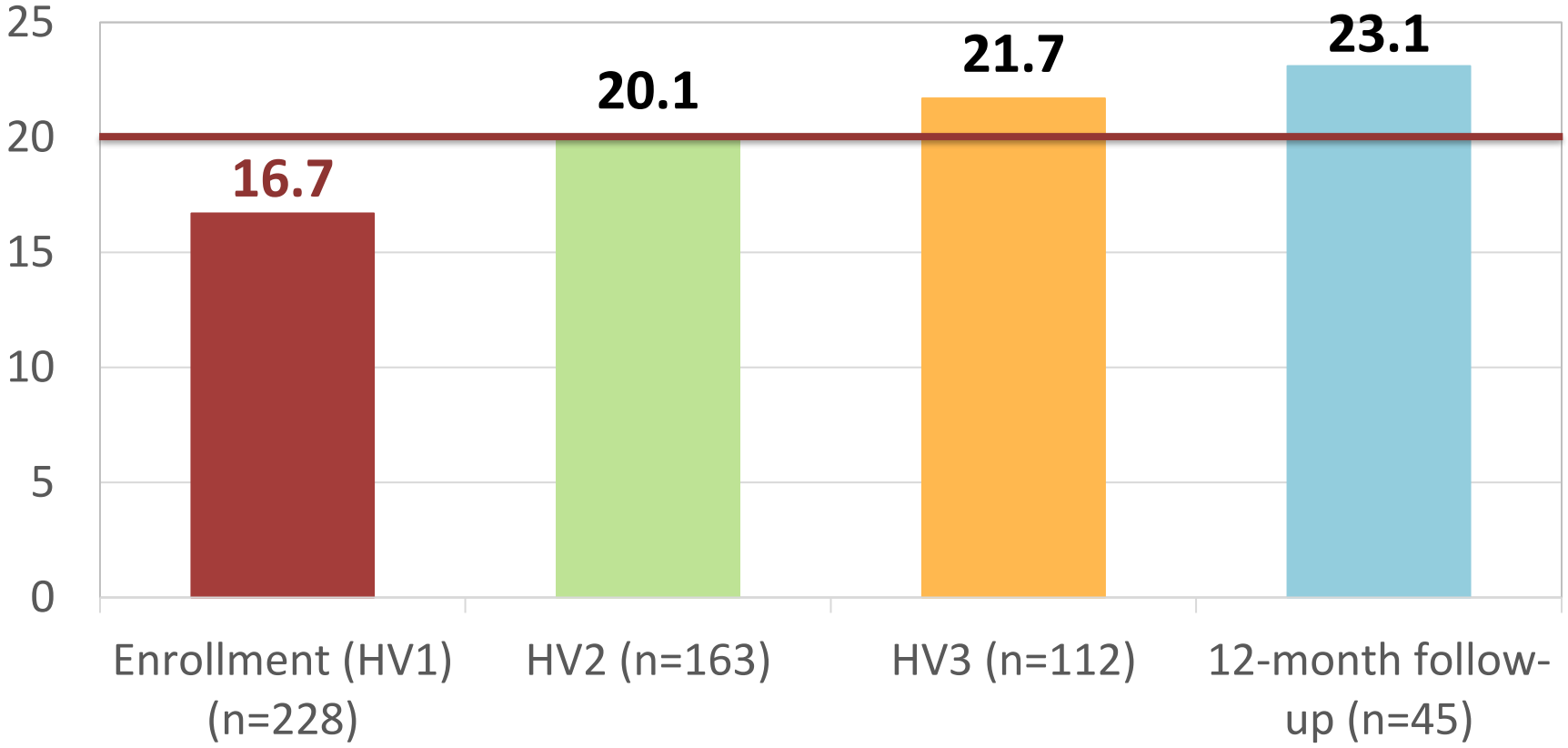
Referrals, Enrollees, and Graduates of SAKB by Age Group



Average Metered Dose Inhaler (MDI) Scores at Enrollment (HV1), HV2, and HV3

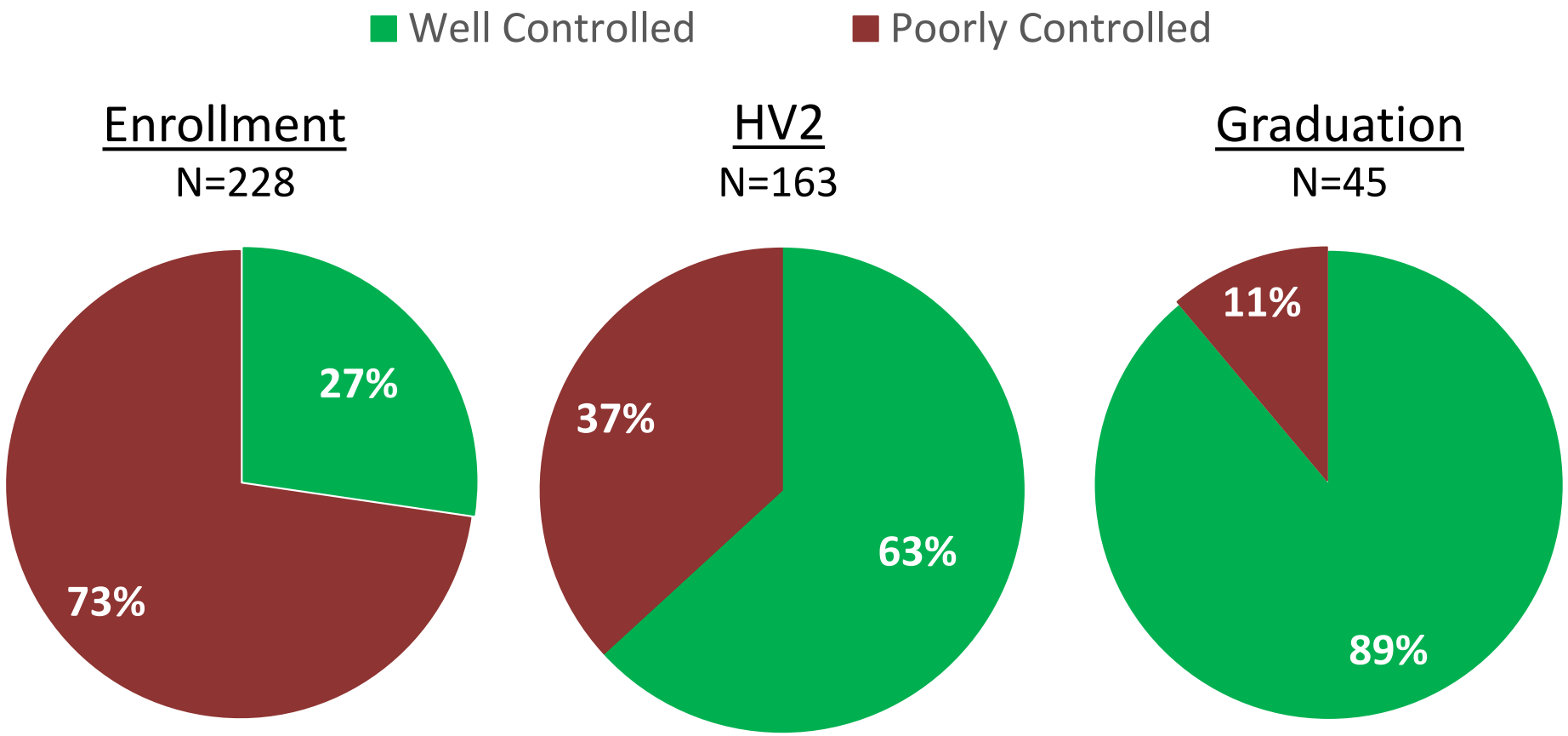


Average Asthma Control Test (ACT) Scores at Enrollment (HV1), HV2, HV3, and 12-month follow-up



(ACT <20=poorly controlled, ACT>19 = well-controlled)

ACT Scores by Status (well or poor control) at Enrollment (HV1), HV2 and Graduation (12-month follow-up)



(ACT <20=poorly controlled, ACT>19 = well-controlled)

Community First Health Plan

- Data on Community First Members is still being analyzed. Initial findings:

- Children with Asthma
  - Community First Members referred to SAKB, and enrolled with one or more home visits
    - **Observed a reduction in ED visits**

SAKB Sustainability (1)

- Status in Bexar County – separate entities:
  - Bexar County / University Health System – County ED & Hospital
  - City of San Antonio – funds SAKB
  - No cost savings transferred for reduced asthma admissions

- Funding through direct contracts, for Value Added Services
  - 2 Health Plans approached

- Funding through Pathways/HUB partnership
  - 2 Health Plans already part of the HUB
  - Developing a pilot with 1 local health plan and the HUB

SAKB Sustainability (2)

- Funding through a government agency
  - Texas HHSC Asthma Control Affinity Group Involvement – Oct 2020 to Jan 2021
    - **the role of the MCO and the referral to community organizations**
  - Texas HHSC Medicaid Topic Nomination Form Submission for CHW reimbursement for services provided related to asthma – Sept 2021
    - RCP Services Handbook, covered benefits:
      - 98960 (asthma education using standardized curriculum, non-physician provider)
      - 99503 (home respiratory therapy)
      - S9441 (asthma education, non-physician provider, per session)

CITY OF SAN ANTONIO
METROPOLITAN HEALTH DISTRICT

SA Kids B.R.E.A.T.H.E.
Building Relationships, Effective ASTHMA Teaching in Home Environments

Questions?

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Center for Health Care Strategies
Better care where it's needed most

Exploring Food is Medicine

February 25, 2022

Made possible by the Episcopal Health Foundation

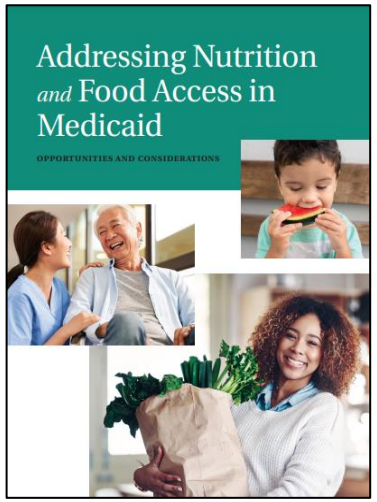
CENTER *for* HEALTH LAW
and POLICY INNOVATION
HARVARD LAW SCHOOL

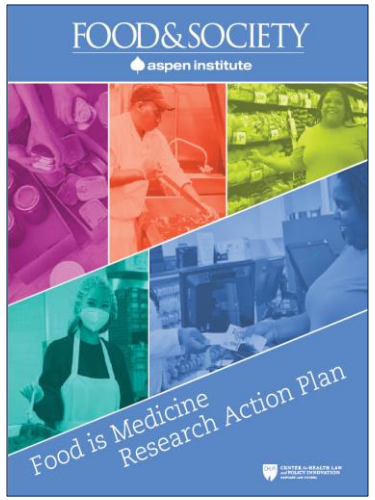
FOOD IS MEDICINE AS ILOS

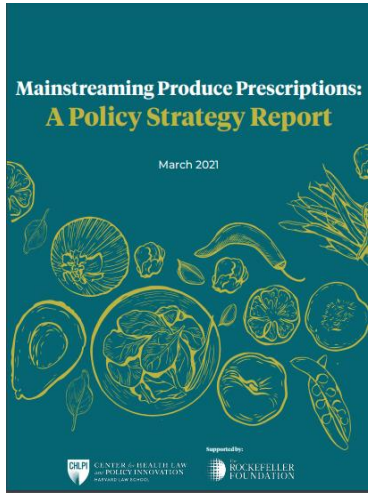
A National Perspective

Katie Garfield, JD
Director, Whole Person Care
Center for Health Law and Policy Innovation
Feb. 25, 2022

Who We Are







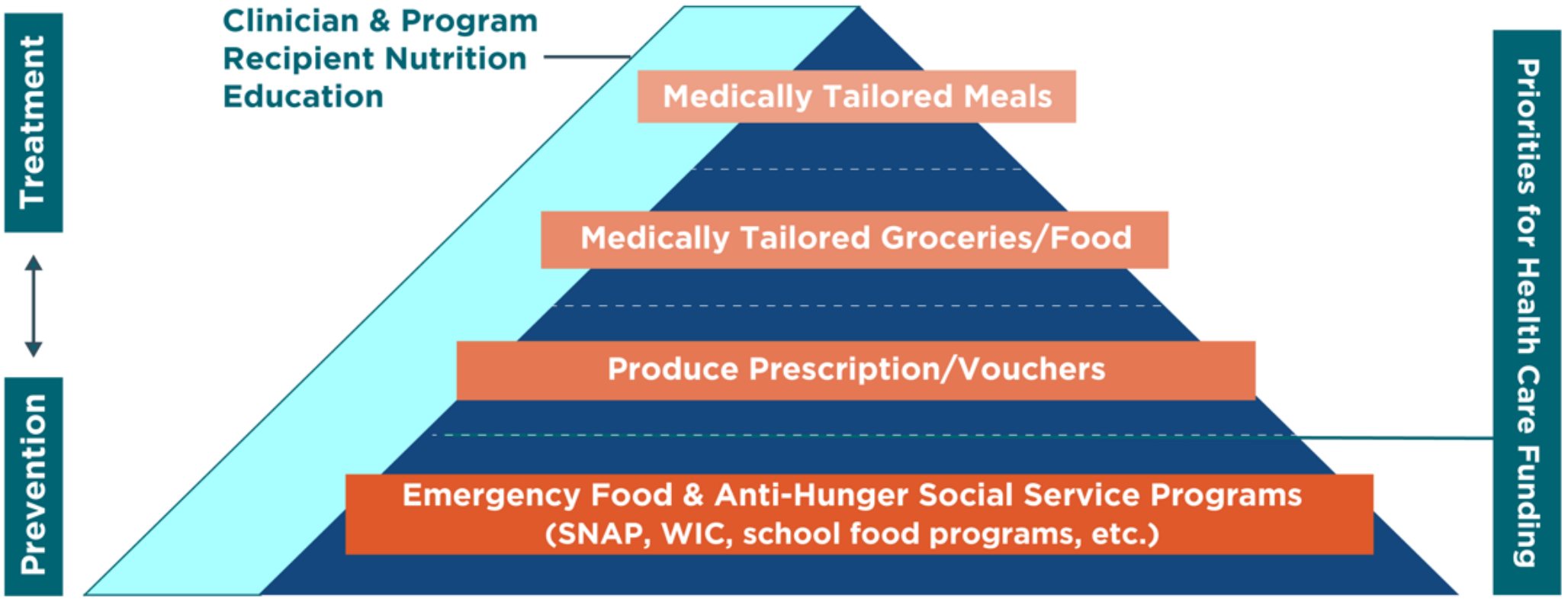
Center for Health Law and Policy Innovation Of Harvard Law School (CHLPI)

- **National Policy Advisor**
  - Food is Medicine Coalition (FIMC)
  - National Produce Prescription Collaborative (NPPC)

- **State Policy Advisor**
  - Food is Medicine Massachusetts (convener)
  - Food is Medicine South Carolina
  - Medically Supportive Food & Nutrition Steering Committee
  - Bi-State Primary Care Association (VT/NH)
  - Idaho Hunger Relief Task Force

- **Individual Organization Policy Advisor**
  - FIMC Accelerator Program – MTM programs in:
    - Florida
    - Indiana
    - Ohio
    - Texas
    - Wisconsin

Food is Medicine – A Spectrum of Services



CHLPI CENTER for HEALTH LAW and POLICY INNOVATION HARVARD LAW SCHOOL

Current Peer-Reviewed Research

Medically Tailored Meals

Health Condition	Outcome	Result
Multiple health conditions	Emergency department visits	⬇
	Inpatient admissions	⬇
	Overall health care costs	⬇
	Admission to skilled nursing facility	⬇
	Self-reported healthier eating	⬆
	Self-reported health status	⬆

Produce Prescriptions

Health Condition	Outcome	Result
Diet-related disease risk, usually as indicated by food security status or BMI	Healthy Eating Index scores	⬆
	Fruit intake, adults	⬆
	Vegetable intake, adults	⬆
	Fruit intake, children	⬆
	Vegetable intake, children	–/⬆
	BMI	–/⬇
	Food security	⬆
	Diastolic blood pressure	⬇
	HbA1c	–

Medically Tailored Groceries

Health Condition	Outcome	Result
Multiple health conditions	Fruit intake, adults	–/⬆
	Vegetable intake, adults	–/⬆
	Fruit intake, children	⬆
	Vegetable intake, children	–
	Daily dietary fiber intake	⬆
	Food security	–
	Diastolic blood pressure	⬇
	Hospital readmissions	⬇
	Self-reported health status	⬆

Notes:

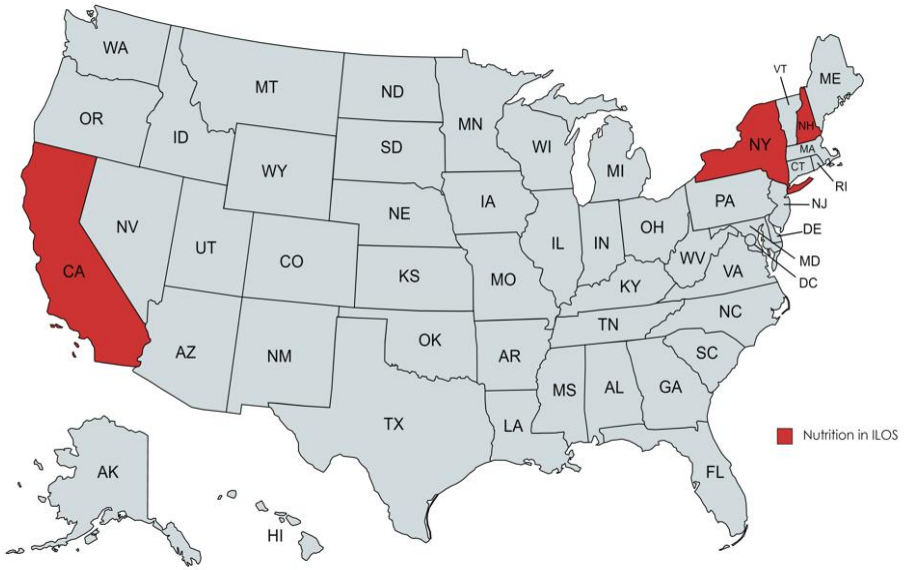
- *Additional findings available in the **Food is Medicine Research Action Plan***
- *More peer-reviewed research on **costs** for both MTM and PRx is forthcoming/in press*

In Lieu of Services (ILOS)

42 C.F.R.§ 438.3(e)(2): An MCO, PIHP, or PAHP may cover, for enrollees, services or settings that are in lieu of services or settings covered under the State plan as follows:

(i) The State determines that the alternative service or setting is a **medically appropriate** and **cost effective substitute** for the covered service or setting under the State plan;

Example States Incorporating FIM in ILOS



New York

- **Service**: Medically tailored meals
- **Substitution**: For Personal Care Aide services time allotted for meal preparation
- **Population**: 18+, 1+ serious chronic illnesses, limited in activities of daily living, 20+ hours of PCA services that include meal prep

California

- **Service**: Medically supportive food/meals/medically tailored meals
- **Substitution**: Avoid services such as inpatient/outpatient hospital services, ED services
- **Population**: Individuals with: chronic conditions, recently discharged or at risk of hospitalization/placement at SNF, extensive care coordination needs

CENTER *for* HEALTH LAW *and* POLICY INNOVATION

HARVARD LAW SCHOOL

1607 Massachusetts Avenue • Cambridge, MA 02138

Connect with us online

chlpi@law.harvard.edu • www.chlpi.org • Facebook & twitter @HarvardCHLPI

Factor Health
Real. Life. Health.

The University of Texas at Austin
Dell Medical School

The Case for Food, Nutrition & Health
A Texas Perspective

Maninder Kahlon, PhD

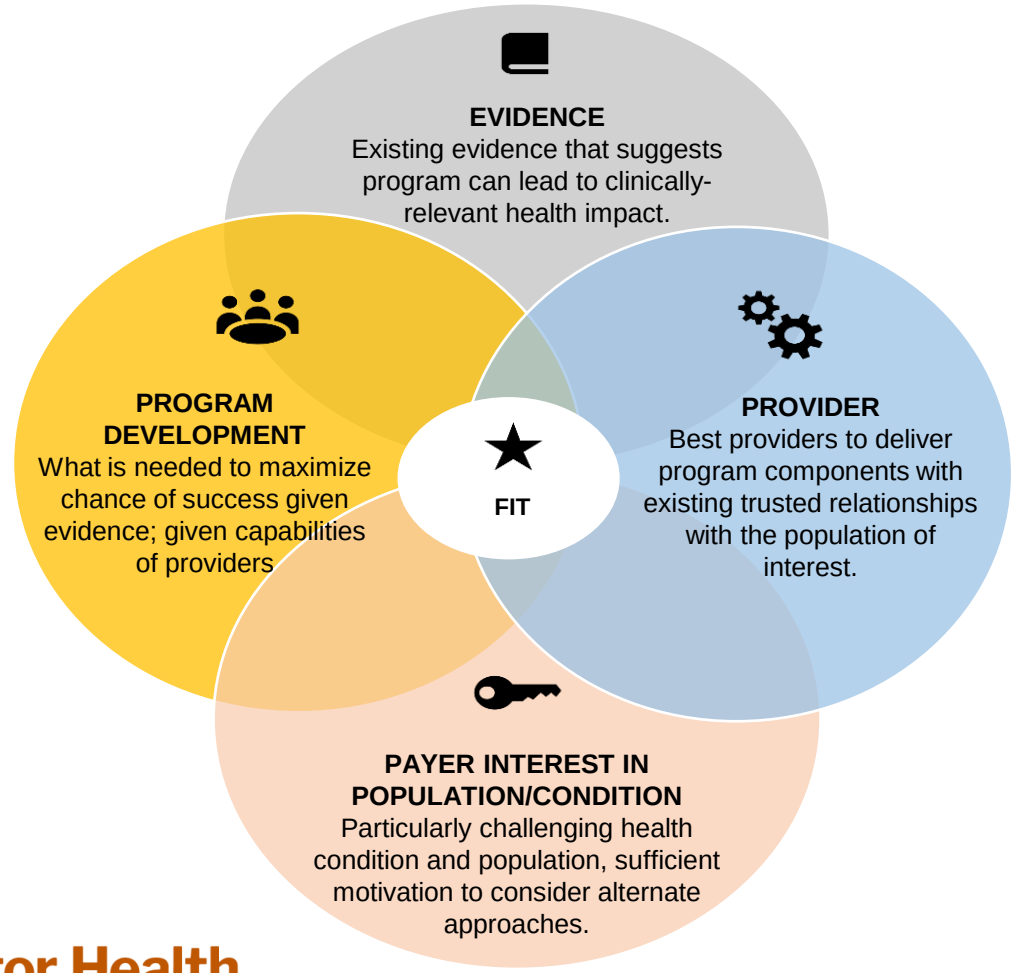
Director, Factor Health
Vice Dean, Health Ecosystem
Assoc Professor, Population Health

Focus

Social interventions, anchored in people's lives, that rapidly improve clinically-relevant measures of health.

- Interventions 4 weeks to 1 year
- ROI in 1-2 years
- Individual and family risk factors.
- Agnostic to social interventions, whatever seems to work best.

Approach



Step 1

Is there an opportunity?

- For whom?
- For what benefit?
- How accomplished at scale?

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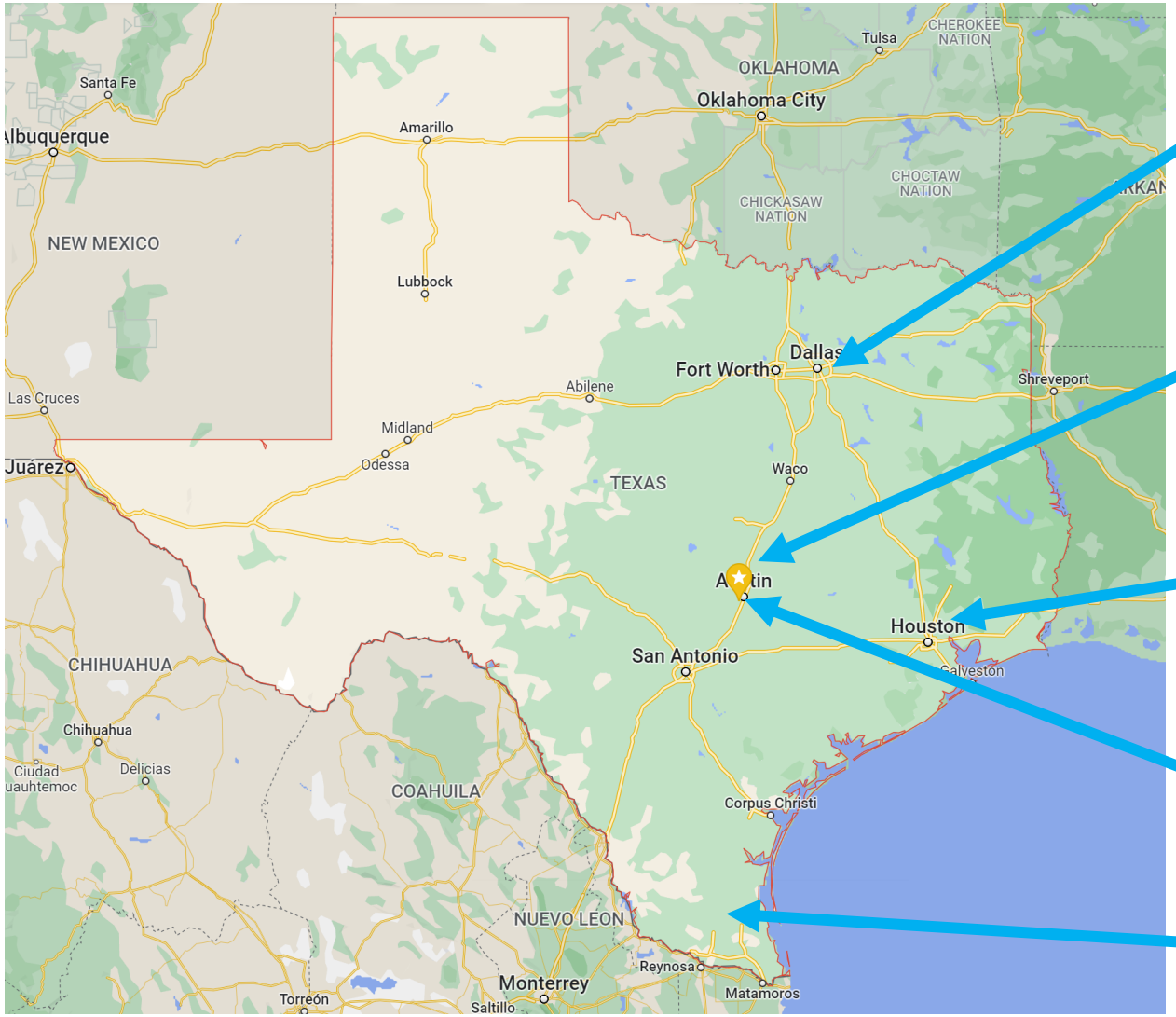
Landscape of food-related work in TX



Older Adults: Medically-tailored meals + mental health for people with diabetes

Older Adults: Medically-tailored meals for people with diabetes

Adults: Early stage Kidney disease (CKD 2/3; Proteinurea)

Families/children: Healthier trajectories

Maternal health and infant outcomes: Gestational Diabetes, Pre-term births; Birthweight.

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Key Ques: Medically-Tailored Meals

OR

Box
1 time a week
Optimized for deliverer

Human
5X a week
Optimized for recipient

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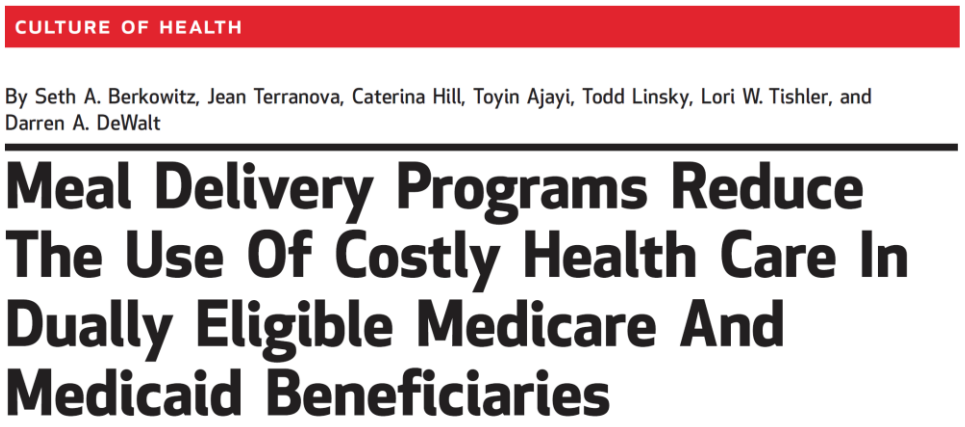
Key Ques: Medically-Tailored Meals

What does delivery result in? That it reduces hospitalization is understood.



CULTURE OF HEALTH

By Seth A. Berkowitz, Jean Terranova, Caterina Hill, Toyin Ajayi, Todd Linsky, Lori W. Tishler, and Darren A. DeWalt

Meal Delivery Programs Reduce The Use Of Costly Health Care In Dually Eligible Medicare And Medicaid Beneficiaries

DOI: 10.1377/hlthaff.2017.0999
HEALTH AFFAIRS 37,
NO. 4 (2018): 535–542

	Emergency Department Visits	
	Incidence rate ratio	**P**
Medically Tailored Meals	0.36	***
Non-Tailored Food	0.54	***
	Inpatient Admissions	
	Incidence rate ratio	P
Medically Tailored Meals	0.41	**
Non-Tailored Food	0.81	
	Emergency Transportation Events	
	Incidence rate ratio	P
Medically Tailored Meals	0.18	***
Non-Tailored Food	0.52	***
	Average Monthly Costs	
	Difference in gross costs	P
Medically Tailored Meals	−$802	***
Non-Tailored Food	−$228	**

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Key Ques: Medically-Tailored Meals

What models of delivery are best – what benefits can be achieved?

Qualitative results suggest benefits of Daily Warm meal delivery model, but relative benefits and cost/benefit not yet clear.

	Older Adult Focus	Health System Condition related to Decision-Making	Relevance of Main Outcomes to Decision-Making	Utility of results for defining quality guidelines for delivery	Models of Meal Delivery Tested to Maximize results
MOW America Incl VNA MOW Dallas site	Yes	Medium/mixed health needs.	Strong/costs. Healthcare & nursing home utilization	Low; no direct biomedical measures.	Yes
Community Servings MA/NC	No	Strong/diabetes	Strong/proximal measures of disease management. Hemoglobin A1C	High; Hemoglobin A1C & other biomedical measures.	No
Texas Dell Med/MOWCTX	Yes	Strong/diabetes, mental health potential.	Strong/proximal measures of disease management. Hemoglobin A1C	High; Hemoglobin A1C & other biomedical measures; Mental Health focus	Yes

Key Ques: Medically-Tailored Meals

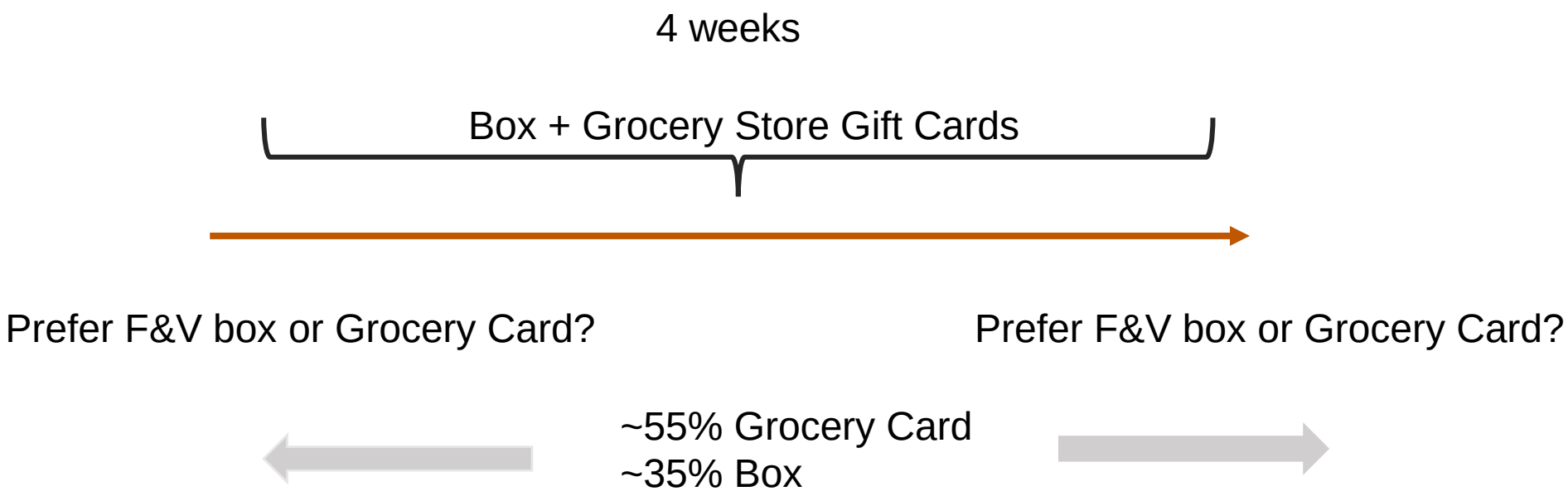
If paid for, what quality measures should we expect?

The current studies underway will help and would benefit from being reinforced through state pilots to finetune quality measures

1. Measures of successful delivery/receipt
2. Measures related to ‘eatability’ – what’s actually eaten.
3. Measures to address management of condition. From current and state pilots, define achievable biomedical targets when delivery is done well. E.g. A1C
4. Person satisfaction
5. + more; room for innovation on measures.

Key Ques: Produce for families

How delivered/how much adopted – Vouchers? Boxes? Choice?



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Key Ques: Produce for families

How much of an impact on health outcomes

Unclear. But reasonable targets can be defined and assessed. For e.g.

Solution	Nominal Reduction (% points)
Tech-driven primary care	2.0 pt
	1.3 pt
	1.1 pt
	1.1 pt
	0.8 pt
	0.6 pt

- ***1.0 adjusted***: 2.0 drop should be reduced by 1.0; it didn't include comparison to control, & most studies how a drop of 1.0 on control arm.
- ***Timeperiod***: 1.2 years average.
- ***Population***: Unmanaged diabetes, (10.7 decr to 8.7) but otherwise members of concierge service.

Key Ques: Maternal & Infant Outcomes

What's known?

a. Can impact maternal health outcomes – e.g. pre-term births
b. Can impact infant outcomes – e.g. birthweight

Key Ques: Maternal & Infant Outcomes

What's Possible?

Table 4. Maternal Outcomes.* Diet intervention against "Usual Care"

Outcome Variable	Treatment Group (N=476)	Control Group (N=455)	Relative Risk (97% CI)	P Value
Induction of labor — no. (%)	130 (27.3)	122 (26.8)	1.02 (0.81–1.29)	0.86
Cesarean delivery — no. (%)	128 (26.9)	154 (33.8)	0.79 (0.64–0.99)	0.02
Shoulder dystocia — no. (%)	7 (1.5)	18 (4.0)	0.37 (0.14–0.97)	0.02
Preeclampsia — no. (%)	12 (2.5)	25 (5.5)	0.46 (0.22–0.97)	0.02
Preeclampsia or gestational hypertension — no. (%)	41 (8.6)	62 (13.6)	0.63 (0.42–0.96)	0.01
Body-mass index at delivery†	31.3±5.2	32.3±5.2		<0.001
Weight gain — kg‡	2.8±4.5	5.0±3.3		<0.001

* Plus–minus values are means ±SD. The number in each group refers to the number of women for whom all delivery data were available.
† The body-mass index is the weight in kilograms divided by the square of the height in meters.
‡ Weight gain refers to weight gain from enrollment in the trial until delivery.

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Landon et al, N Engl J Med 2009; 361:1339-1348
DOI: 10.1056/NEJMoa0902430

Key Ques: Maternal & Infant Outcomes

- Start as early as possible in pregnancy to maximize results
- New opportunities to impact infant and mother with additional 6 month coverage!

Summary

1. Evidence in various stages for various conditions;
   a. That there will be impact is clear
   b. How much, delivered how, cost/benefit needs more attention
   c. Creativity in delivery, assessment of adoption will be key to maximize results.

2. Payment approaches
   a. Incentivize focusing on outcomes that matter.
   b. Require identification of 1 or more quality measures to test
   c. Maximize impact of pilot periods by seeking variety of solutions, as much as possible only constrained by the results we seek.

Questions/Discussion

Contact us: mkahlon@austin.utexas.edu

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The University of Texas at Austin
Dell Medical School

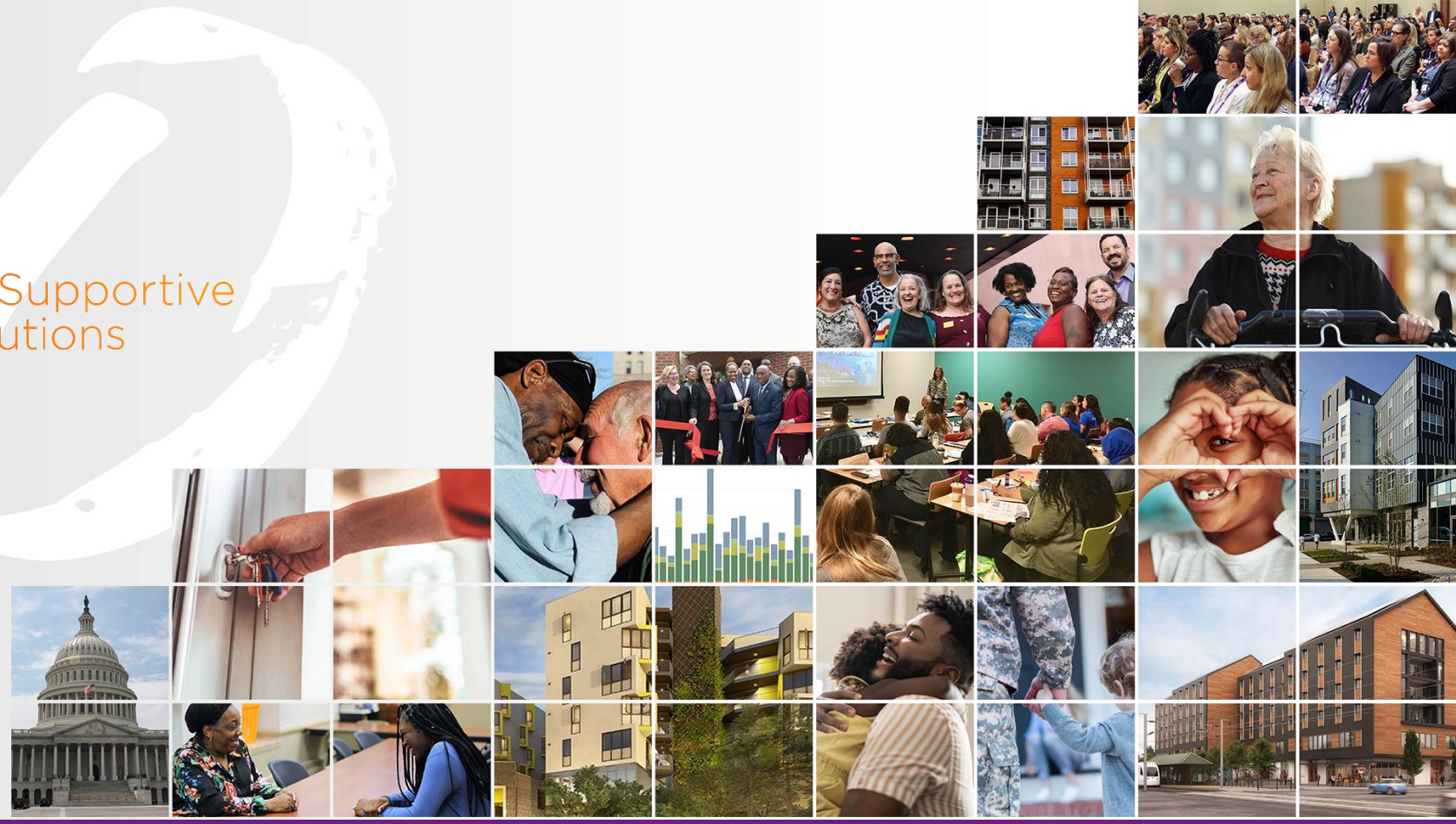
Center for Health Care Strategies
Better care where it's needed most

Exploring Supportive Housing

March 22, 2022

Made possible by the Episcopal Health Foundation

CSH 30 Years of Supportive Housing Solutions



Permanent Supportive Housing: Defining and Financing

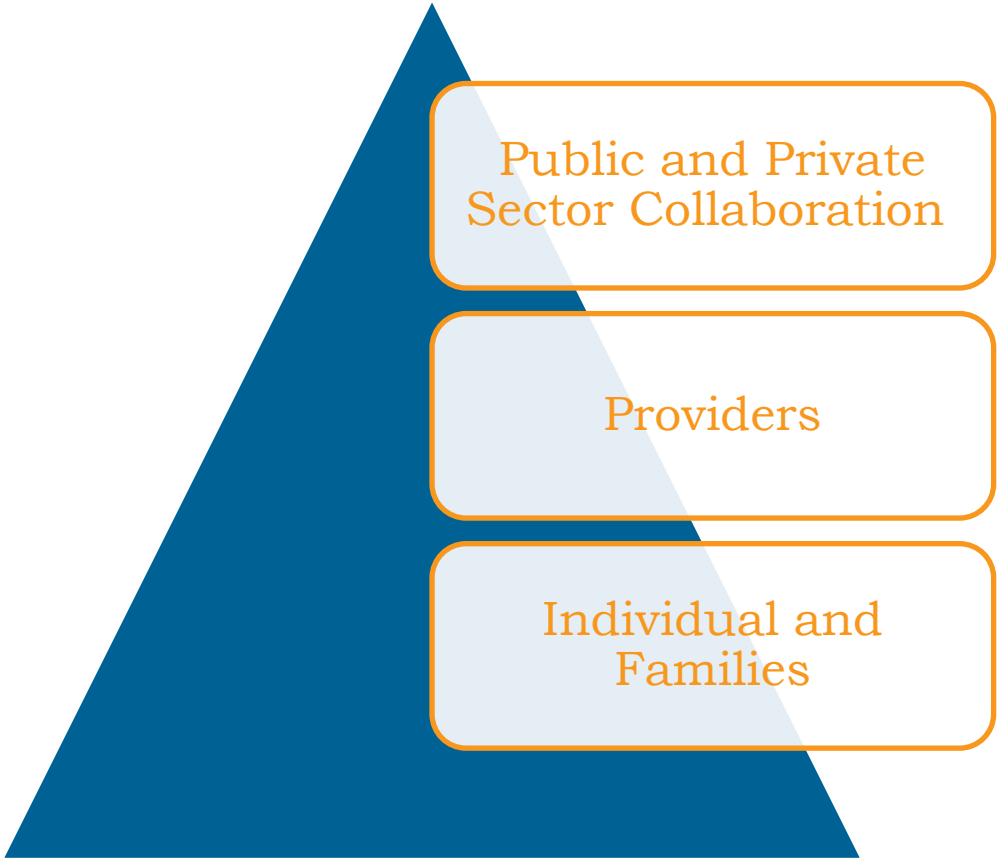
Marcella A. Maguire, Ph.D.
Director, Health Systems Integration, CSH

Maximizing Public Resources

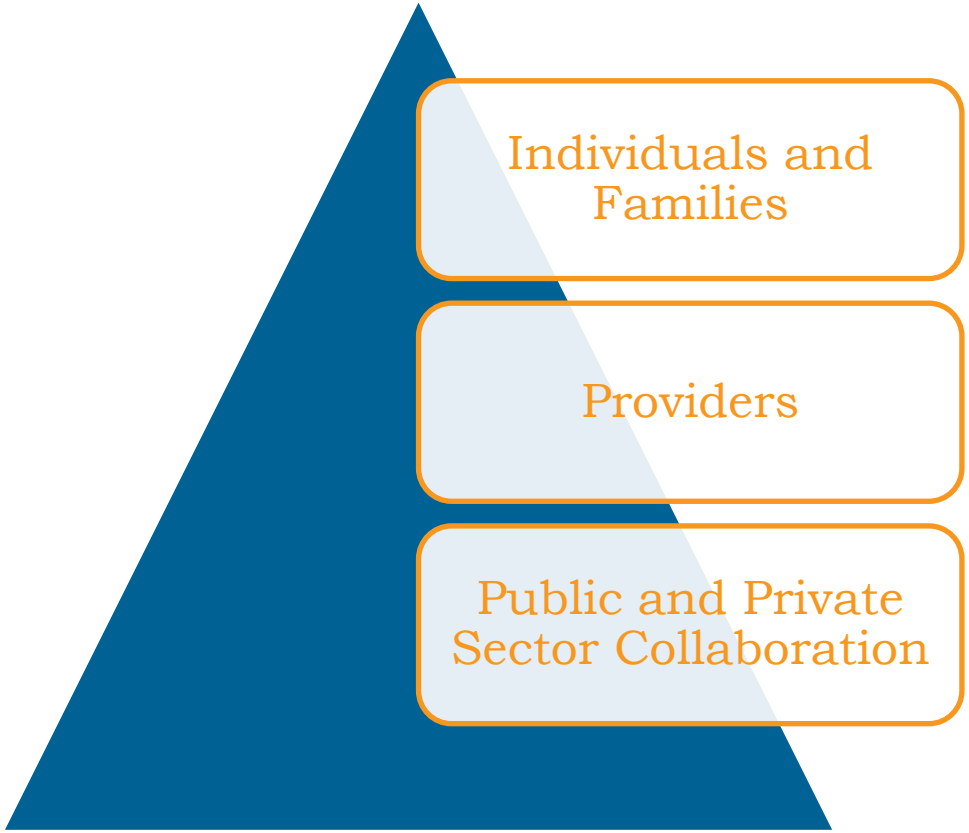
CSH collaborates with communities to introduce housing solutions that promote integration among public service systems, leading to strengthened partnerships and maximized resources.

Navigating Multiple Sectors: *Where Does the Burden of Coordination Lie?*

- **Current Reality**

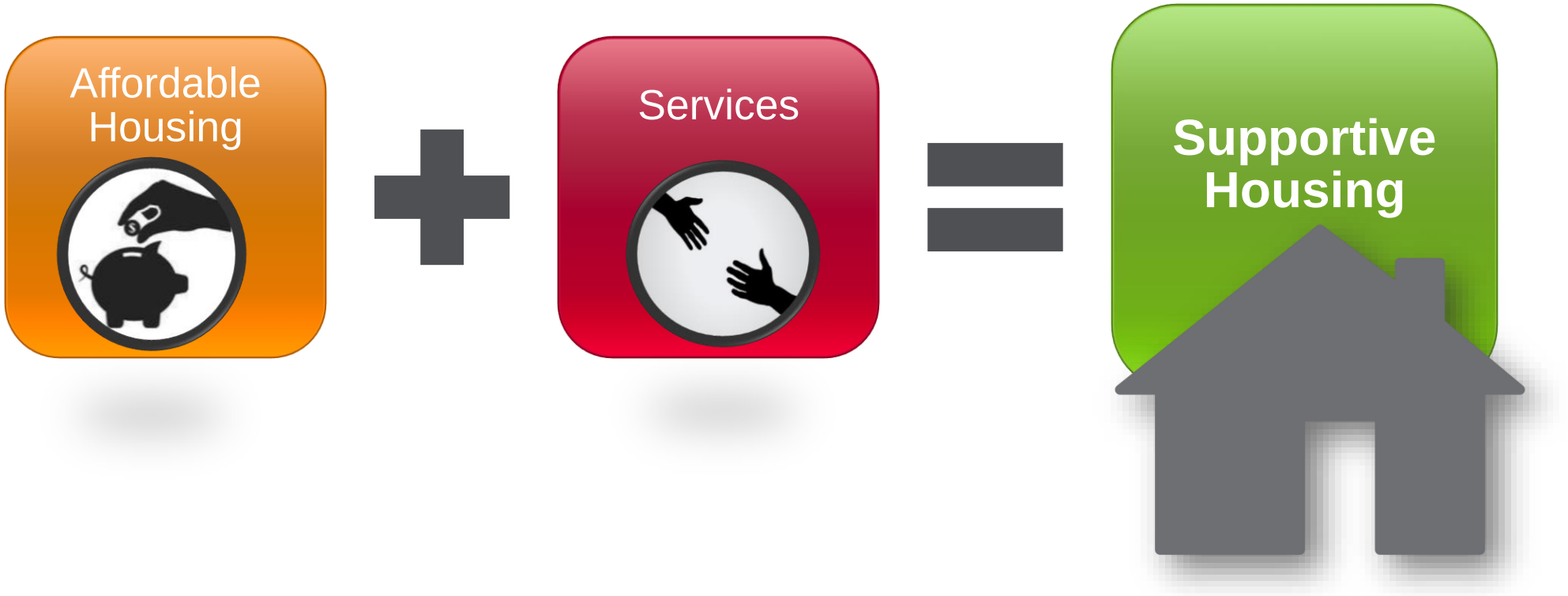


- **Future Vision**



Supportive Housing is the Solution

Supportive housing combines affordable housing with services that help people who face the most complex challenges to live with stability, autonomy and dignity.



How do you describe Supportive Housing?

Supportive Housing is…

Housing + Supportive Services + Property Management + Community

Permanent

Affordable

Independent

Flexible

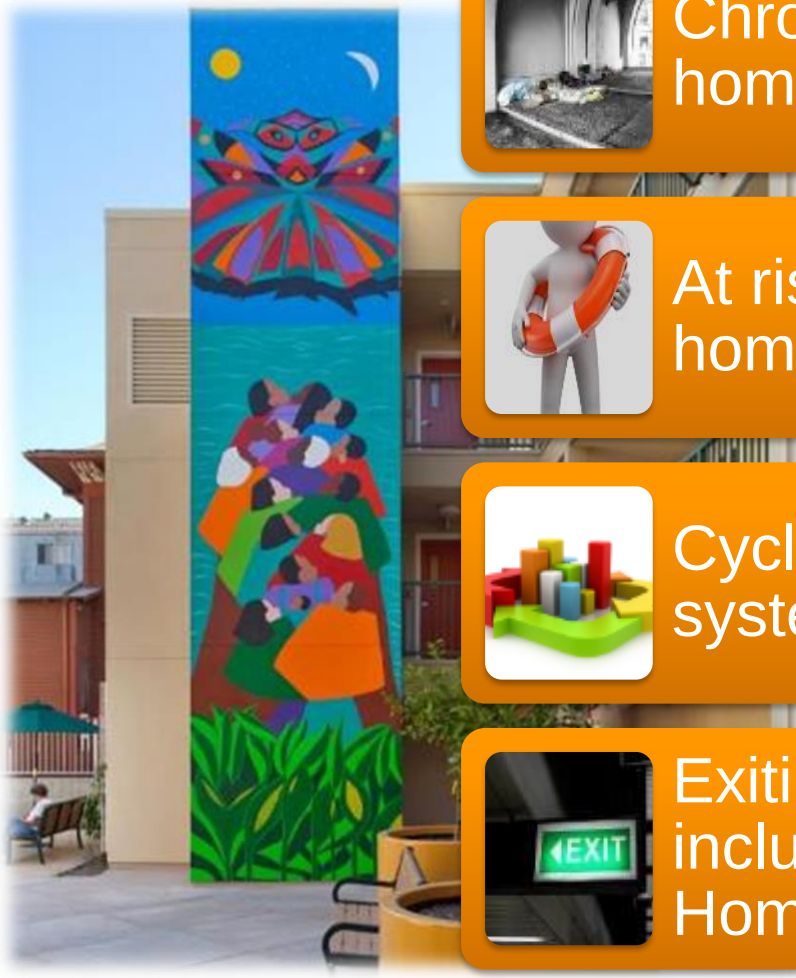
Voluntary

Tenant-Centered

CSH

Targets households with multiple barriers to stable community living

Supportive Housing is for people who are…



Chronically homeless

At risk of homelessness

Cycling through systems

Exiting institutions including Nursing Homes

CSH

Supportive Housing Outcomes

Supportive Housing Generates Significant Cost Savings to Public Systems, including decreased use of…

Homeless shelters

Medicaid

Hospitals and Emergency rooms

Jails and prisons

Supportive Housing Outcomes

Supportive Housing Benefits Communities.

Improves the safety of neighborhoods

Beautifies city blocks

Increases or stabilizes property values over time

CSH

Key Components of Supportive Housing

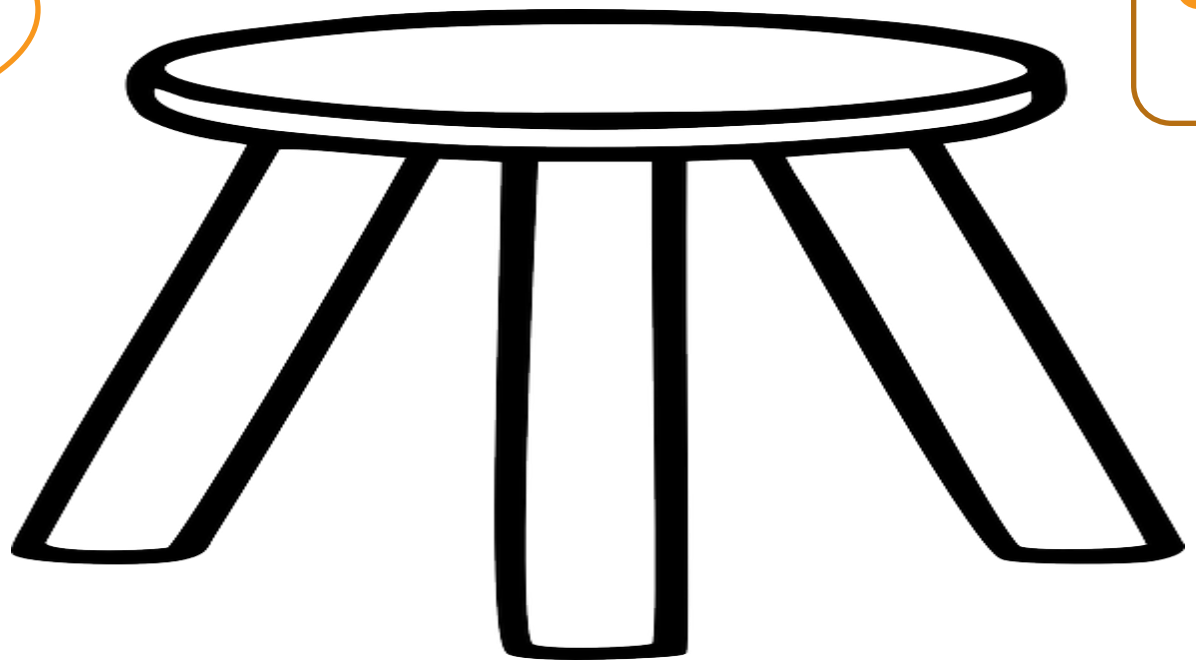
1. Targets households with multiple barriers
2. Provides unit with lease
3. Housing is affordable
4. Engages tenants in flexible, voluntary services
5. Coordinates among key partners
6. Supports connecting with community

CSH

The 3 legged stool of Supportive Housing Financing

CAPITAL

Building the property



OPERATING

Keeping the rent affordable

SERVICES

In Home Services

CSH

Housing is affordable.

Sources of Affordability

- **Continuum of Care**
  - Formerly Shelter + Care (S+C) and Supportive Housing Program (SHP)
- Housing Opportunities for Persons with AIDS (HOPWA)
- Veterans Administration Supportive Housing (VASH)
- Housing Choice Voucher (HCV)
- HOME Tenant Based Rental Assistance (TBRA)
- State/Local rental subsidy program
- Tenant paid rent
- Others…

CSH

Services are flexible, voluntary and assertive offering Whole Person Care Coordination

Sources of Services Funding

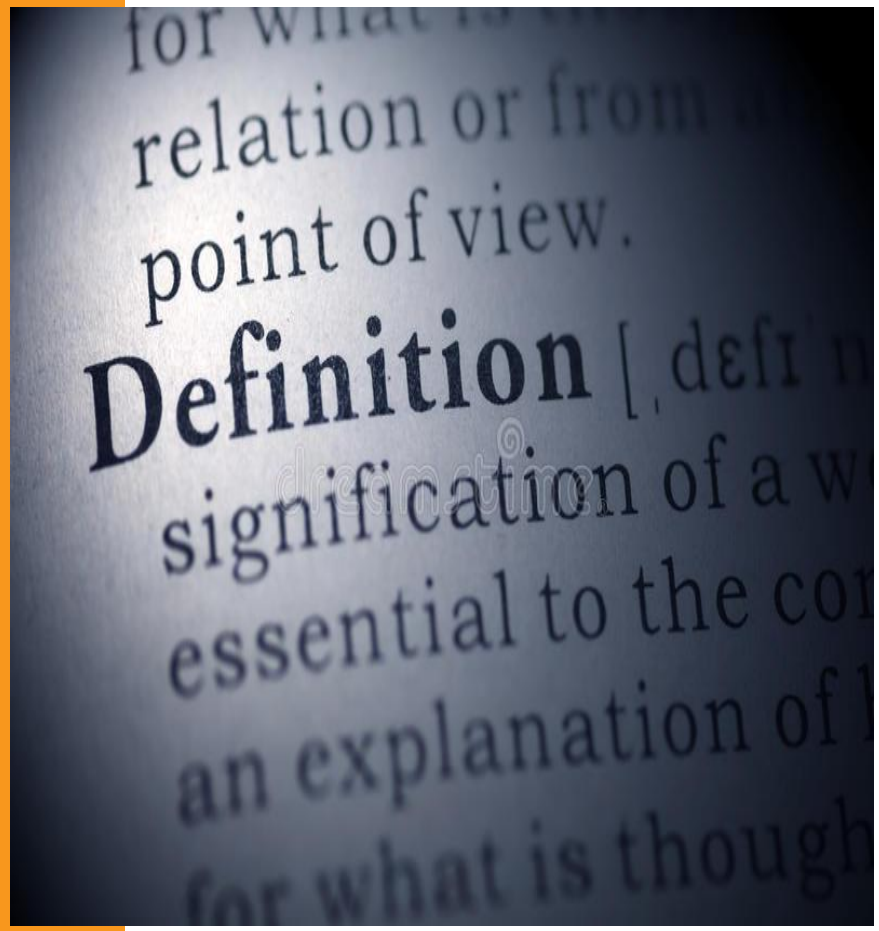
- Medicaid Benefit
- SAMHSA Block grants
- Veterans Administration Services
- HUD Supportive Services
- Philanthropy
- State/Local Services funds
- Others…

CSH

Example: Minnesota

Services definitions:

Housing Transition Services



- Planning
- Applying for Benefits
- Housing search and applying
- Develop a personal budget
- Negotiate a lease
- Organizing the move
- Addressing any barriers to housing

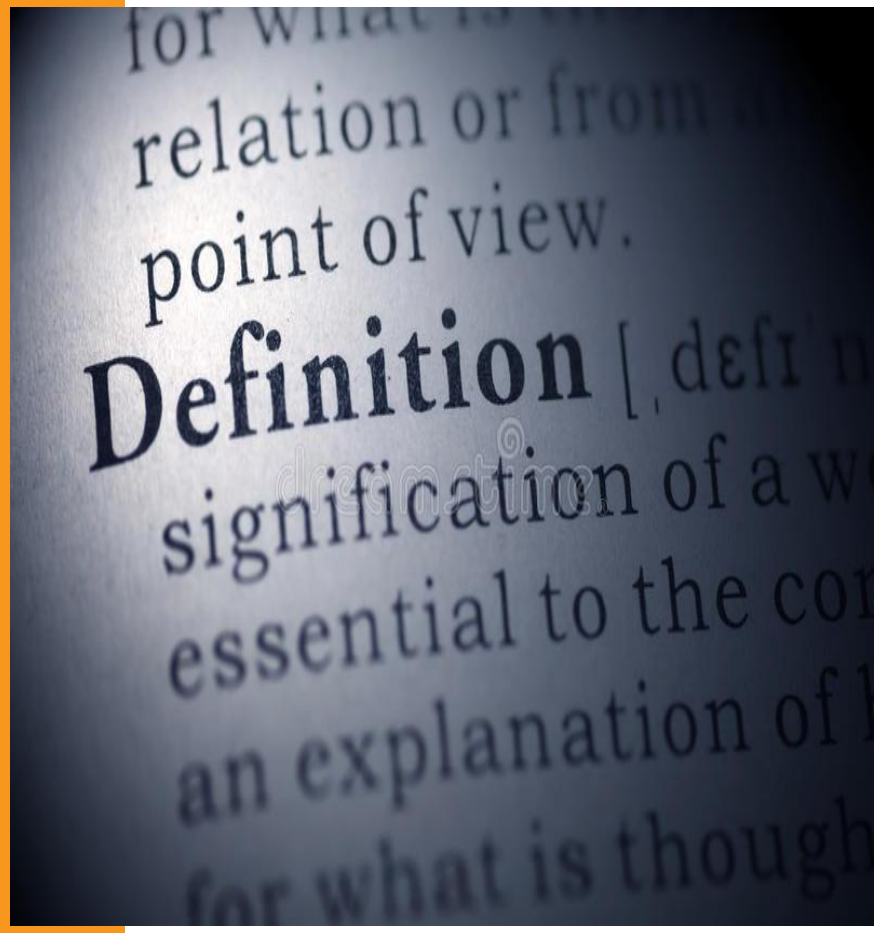
MN HSS Website

CSH

Example: Minnesota

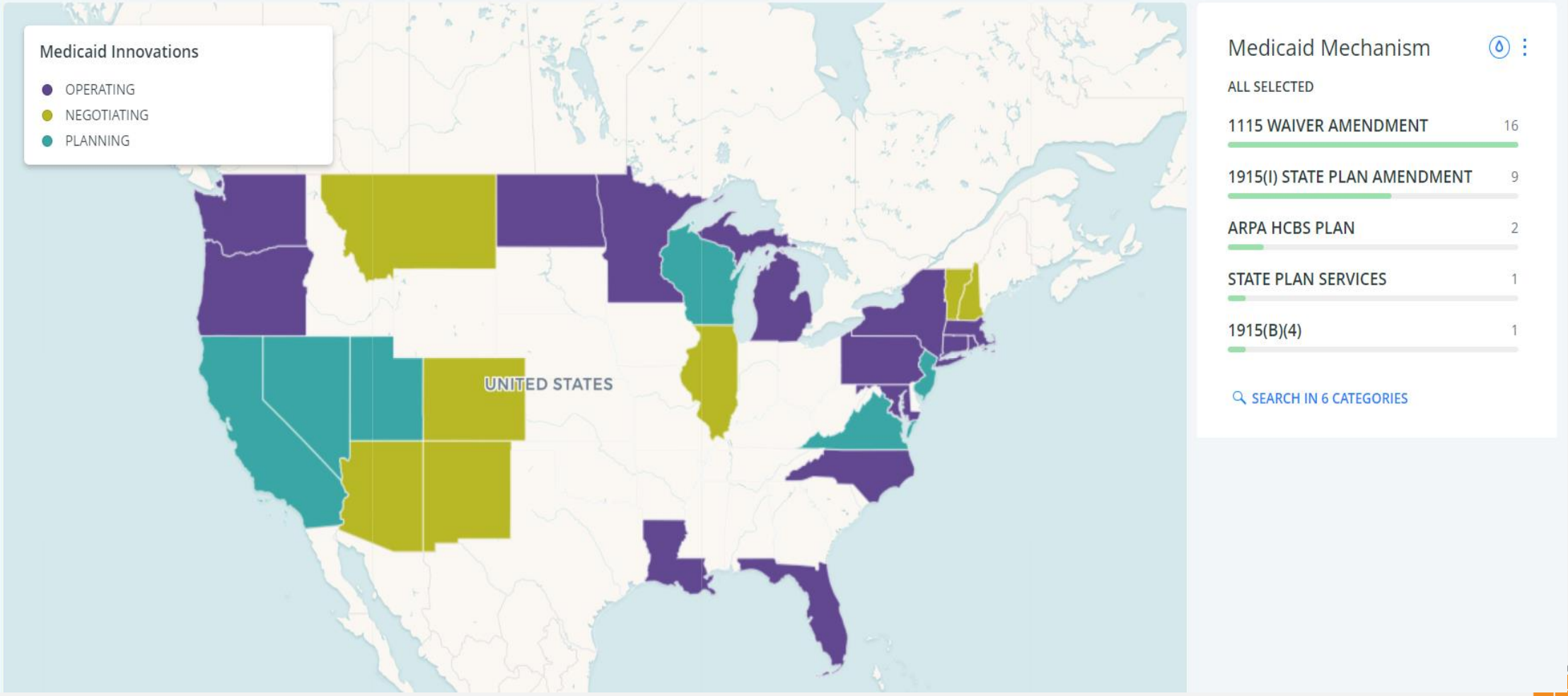
Services definitions:

Housing Sustaining Services



- Planning
- Service Coordination
- Landlord relationship support
- Addressing any behaviors that threaten tenancy
- Assisting with accessing community resources
- Building natural supports
- Addressing any barriers to maintaining housing

Status of states coverage of housing related services via Medicaid



[CSH Map of states]

State Policy Choices

Priority Populations

- Behavioral Health
- Homeless and Housing Unstable
- Complex Care/ High Cost, High Need
- Money Follows the Person Population

Medicaid Authority

- 1115 Waivers
- 1915(i) Authority
- 1915 (b) (4)

Delivery Systems

- Managed Care
- FFS
- Value Based Payments or APMs

Where do the Housing and Services Integrate?

- At the State Level
- At the County Level
- At Coordinated Entry
- At the MCOs

CSH

Texas Supportive Housing Institute- Held- January, 2022

[Texas Supportive Housing Institute Details]

THANK YOU!

Follow up at Marcella.Maguire@csh.org

Twitter- @cella65

Additional Resources

The following resources were shared via the Zoom chat during this learning session:

- HHSC's Home and Community-Based Services – Adult Mental Health program
- National Academies of Sciences, Engineering, and Medicine study on impacts of permanent supportive housing
- Literature review from CHS on supportive housing outpatient outcomes
- Program evaluation from Portland, OR: Multnomah County FUSE Report
- Program evaluation from Denver, CO: Denver Supportive Housing Social Impact Bond Initiative
- Minnesota Medicaid's Housing Stabilization Services
- Texas Medicaid's 1915(i) State Plan HCBS benefit

TEXAS Health and Human Services

Behavioral Health Housing Support Initiatives

Helen Eisert, LCSW-S, Senior Housing Policy Advisor
Sarah Gonzalez, LCSW, Project Implementation Manager
IDD BH Services Department

Agenda

- Current Programs
- Upcoming Pilots
- Potential Opportunities

Investment in Housing

- Significant federal resources provided to state agencies and local governments in the last two years in the form of COVID relief funds.
- HHSC provided direct housing assistance in the form of temporary rental subsidies to individuals with serious mental illness since 2013.
- HHSC works closely with the Texas Department of Housing and Community Affairs and Texas State Affordable Housing Corporation to increase access for people coming out of institutions.

TEXAS
Health and Human Services

Current Programs

- Supportive Housing Rental Assistance
- Healthy Community Collaboratives
- COVID-funded housing programs
- Partnerships with Texas Department of Housing and Community Affairs and Texas State Affordable Housing Corporation

TEXAS
Health and Human Services

Current Housing Challenges

- People can have increased lengths of stay in health institutions due to lack of a suitable place to live in the community.
- Supportive housing providers describe challenges related to people using rental subsidies.
- People can be left behind due to significant barriers:
  - Lack of rental history
  - Prior justice involvement
  - Poor credit
  - Previous evictions

TEXAS Health and Human Services

Money Follows the Person Behavioral Health Pilot

2012-2017: Intervention

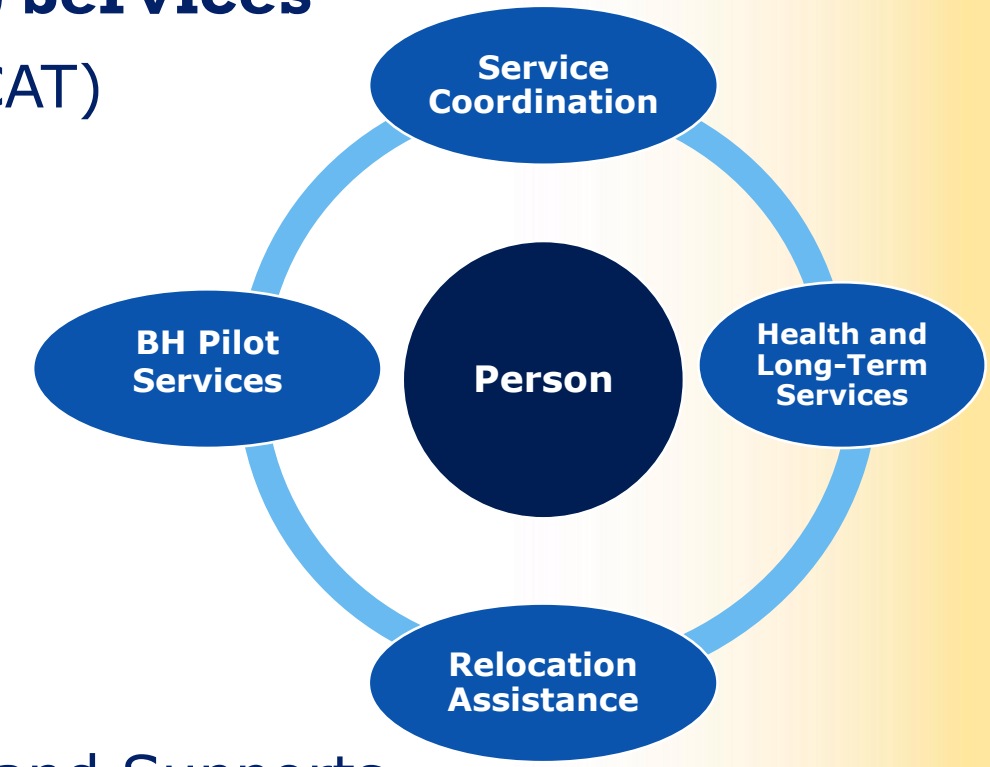
- Transitioned adults with mental illness from nursing facilities to communities
- Addressed barriers for this population and supported them in their communities
- Partnered with managed care organizations (MCOs), providers, researchers, STAR+PLUS members, local mental health authorities (LMHAs), and others.
- Tested positive changes to Medicaid system

TEXAS
Health and Human Services

Behavioral Health Pilot Structure

Behavioral Health Pilot (BHP) Services

- Cognitive Adaptation Training (CAT)
- Substance use counseling
- Employment assistance
- Housing location assistance



Managed Care Partnership

- Assessment and referral
- Service Coordination
- Health and Long-Term Services and Supports
- Relocation Assistance
- Weekly team meetings (Pilot team, MCOs)

TEXAS Health and Human Services

BHP Outcomes

- 450+ transitioned to the community.
- 70 percent completed a year in the community, per independent evaluation.
  - Over 65 percent remained in the community.
- Sustained improvement in social and occupational functioning, community ability, quality of life.
- Increased independence examples:
  - Work at competitive wages,
  - Driving,
  - Volunteering,
  - Getting an education, and
  - Leading peer support groups.
- Net Medicaid savings were over $24.5 million.

TEXAS Health and Human Services

BHP Housing Specialist

- Added to provide the intensive housing navigation support required to convert voucher issuance to leases.
- Support included:
  - Obtaining documents needed for subsidized housing;
  - Providing transportation; and
  - Filing appeals or reasonable accommodation requests when housing was denied.

TEXAS
Health and Human Services

MCO Transition Pilot

- Pilot Service Areas: Travis and Bexar counties-
  - Amerigroup,
  - United HealthCare,
  - Molina and
  - Superior.
- Embeds a specialized position in each MCO to transition people with serious mental illness from nursing facilities to STAR+PLUS Home and Community Based Services.
- Provides support prior to discharge and up to a year after community transition.
- Includes intensive transition services and coordination with nursing facility staff, relocation specialists, LMHA, and MCO staff.

TEXAS
Health and Human Services

Bridge to STAR+PLUS Pilot

- Will transition people from state hospitals to STAR+PLUS HCBS services in Travis and Bexar counties, diverting them from nursing facilities.
- Provides intensive supports before and after transition to community including:
  - LMHA Transition Team comprised of a Transition Specialist and Peer Support Specialist.
  - Access temporary rental assistance funds.
  - Partnership and coordination between state hospital, LMHA, MCO, and other community resources.
- University of Texas Health Science Center at San Antonio Center for Excellence will provide technical assistance regarding rehabilitative intervention (CAT).

TEXAS
Health and Human Services

Potential Opportunities

- Housing navigation
- Landlord engagement and incentives
- Tenancy supports to sustain housing

TEXAS
Health and Human Services

TEXAS
Health and Human
Services

Questions?

TEXAS
Health and Human Services

Helen.Eisert@hhs.texas.gov

Sarah.Gonzalez05@hhs.texas.gov