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Spotlight Series

Partnership between UPMC Health Plan and Community Human Services: Cultivating Health for Success

John Lovelace,
President of UPMC for You & President of Government Programs and Individual Advantage Products, UPMC Health Plan

Everett McElveen,
CEO,
Community Human Services

The NORC Medicaid Managed Care Organization (MCO) Learning Hub shares timely and relevant resources to support Medicaid MCOs and other stakeholders in improving the health of their members and increasing advancements in health equity and health care transformation. We encourage you to share your experiences and feedback on future Medicaid MCO Learning Hub work so we can better serve your needs. To start the conversation or join our distribution list, please email us at MCOLearningHub@norc.org.

The Medicaid MCO Learning Hub "Spotlight Series" highlights key initiatives addressing social determinants of health (SDOH) and health equity that are driven by, or in partnership with, MCOs to inform the Robert Wood Johnson Foundation (RWJF) and its grantees. In addition, the series provides MCOs, community-based organizations, states, and other key stakeholders with examples of successful models of organizations working together to advance health equity.

This "Spotlight" explores a unique partnership between an MCO and a local government housing division, where the MCO's financial support helps the plan's Medicaid members find, obtain, and maintain affordable housing units. This type of partnership could be considered by other MCOs/health plans, seeking innovative solutions to support Medicaid members experiencing unstable housing and prevent homelessness.

Safe and affordable housing enhances quality of life and improves health outcomes.[1] Given the growing need for affordable housing and housing support among Medicaid members, Medicaid MCOs are increasingly investing in this critical need.[2] While some MCOs are implementing housing programs for their members to fulfill a Medicaid managed care contractual requirement, many are investing in housing as MCOs better understand that tackling this SDOH need leads to healthier members. Healthier

[1] Centers for Disease Control and Prevention. (n.d.). Social Determinants of Health|Healthy People 2020. https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health.

[2] Community Catalyst. (n.d.). Healthy Investments: Leveraging Health Plan Capitol for Affordable Housing and Community Development. https://www.communitycatalyst.org/resources/publications/Healthy-Investments_final.pdf.

membership also reduces unnecessary health care utilization and may bring a strong return on investment.

UPMC Health Plan, part of the UPMC integrated delivery and finance system headquartered in Pittsburgh, Pennsylvania, provides services to more than 3.9 million members throughout Pennsylvania and parts of Ohio and Maryland. **Community Human Services (CHS)** is a Pittsburgh-based nonprofit that empowers individuals and families to live in stable housing, connect to community resources, build relationships, and access quality food.

NORC's Medicaid MCO Learning Hub recently spoke with staff from both UPMC Health Plan and CHS to discuss their partnership, including the background, services offered, contractual structure, and goals.*

Program & Partnership Background

Q: Can you describe the background on your partnership?

This all started with observations shared by our UPMC Health Plan care management staff that some of our members face substantial hurdles to maintaining stable health. In particular, our staff observed that those members facing the greatest challenges to stable health were homeless or in unstable housing. We conferred with the Allegheny County Department of Human Services, which administers the HUD Continuum of Care funds and coordinates publicly funded programs addressing homelessness.

We worked with stakeholders to establish basic criteria for participation in the program. To be included, individuals needed to meet HUD's definition of "homeless" and to have had a significant number of unplanned or low-value health care expenses in prior years. Many individuals who met the criteria also had significant mental health and/or substance use disorders. The County suggested we partner with CHS as they have tremendous experience in running supportive housing programs.

PROGRAM BACKGROUND

CHS started over 50 years ago as a small housing program and has evolved into a full-scale housing services provider that operates programs spanning HUD's Continuum of Care. This made them an ideal partner for our Cultivating Health for Success pilot in 2008.

The program started under the Shelter Plus Care Program for individuals who met the HUD definition of "homelessness."[3] In early 2019, we proposed expanding services to a broader group of people who were housing insecure in some significant way and had health issues, rather than focusing only on individuals who met HUD's documentation requirements. We also began to look more prospectively at the upstream risk of our members. In other words, we use predictive analytics to identify Medicaid recipients who are on a path to significant use of low-value health care and who are likely to benefit from stable housing and enhanced care coordination, rather than waiting for someone to experience homelessness and high levels of unplanned care.

> **"We're trying to recognize that health and housing crises are multidirectional; we recognize that people are in uninhabitable situations that are exacerbating their health challenges. The health system does not always capture people's vulnerability and may not recognize the housing continuum of care." –** ***UPMC Health Plan***

Housing vouchers were critical to the project's growth. By using vouchers, we had full collaboration from the city and county housing authorities, and because vouchers are income based, we did not have to document chronic homelessness and disability to house individuals, which can be challenging. Although both Pittsburgh and Allegheny County have housing authorities, we find that many housing vouchers end up not being used, because people often struggle to navigate the process to use them in the 90-120 days that they're available. While the vouchers are cycled around without filling a housing need, many individuals remain on a multiyear waiting list. Our program now helps to increase the total number of Housing Choice Vouchers accepted in these service areas.

Our priority is stabilizing a member's housing circumstances and ensuring that a member can stay in the home obtained through the program indefinitely, regardless of insurance enrollment. One main reason for this program's success is that UPMC Health Plan and the CHS social work team work very closely together towards a common goal. Our organizations regularly schedule case conferences, and we both engage in member advocacy. If we at CHS see a member falling through the cracks, we

[3] U.S. Department of Housing and Urban Development. (March 8, 2019) HUD's Definition of Homelessness: Resources and Guidance. https://www.hudexchange.info/news/huds-definition-of-homelessness-resources-and-guidance/.

have someone at UPMC Health Plan whom we can contact to help step in.

Populations Served

Q: Can you describe the population served by this partnership and the process for enrolling members in housing support services?

This is something we're still discussing and refining. Currently, individuals are referred for housing support every month and then they roll over each month if they're still in the program. No member is considered fully enrolled in the program until CHS has helped them secure housing and the member agrees to continue working towards the goals they set in their individualized care plan with social workers from both organizations. The process begins when UPMC Health Plan's care management team identifies members who are experiencing homelessness or housing instability. Referred members have either a history of low-value health care use or are identified as likely to do so in the immediate future. From there, the community team—comprising a registered nurse, social worker, and community health worker—does a clinical review, works with the member to create a service plan, and makes a referral to CHS.

Next, CHS performs an initial screening to determine whether the person is a good fit and if so, they are referred to the intake team. The intake team and CHS's social work team are responsible for conducting the housing search and enrolling the new member in benefit programs. CHS has expertise in navigating the system, such as identifying landlords who accept housing vouchers, and ensures the individual is supported holistically. The most common barriers to entering housing are pending criminal charges, a criminal history, or an eviction history. CHS works to find housing alternatives to overcome these barriers. Once the member is housed, the UPMC Health Plan team remains involved to make critical clinical connections.

In 2020, the program served 101 people, with 52 successfully finding housing or remaining housed. It is important to balance the number of people we think we can house with the number of members who remain stably housed. The number of members finding a place to call home each month fluctuates, because the housing authority process is out of our control; if vouchers are delayed, it can delay our housing uptake. For example, the housing authorities were closed in June and July due to COVID-19. We started off the year with 29 people housed and, despite the closures, we had housed 52 people by the end of the year and have another 49 working with CHS to obtain a home and appropriate subsidy. In some instances, individuals may disengage with services, others pass away, or others are "resolved" in that they may move in with a family member or move to a different state.

> **"This partnership works because we effectively need each other—everyone brings a set of skills. Additionally, recipients of this service are viewed more favorably as tenants by landlords who know they come with a team of dedicated professionals supporting them to succeed." – *UPMC Health Plan***

Barriers & Challenges

Q: Were there any contractual barriers or challenges to this partnership that you needed to overcome? If so, how did you overcome them?

Ensuring the contract worked for both organizations has certainly been a learning experience on both sides. We are in a fifth version of the contract and there have been a lot of updates along the way to manage the alignment of incentives.

In the original contract, funding for 25 openings came from Shelter Plus Care money to serve chronically homeless adults; it morphed into 25 slots of Permanent Supportive Housing as Shelter Plus Care was phased out at the national level. The money is administered through the local Continuum of Care, which is managed by Allegheny County Department of Human Services. The second major iteration in 2019 incorporated more incentives into the contractual arrangement and generated partnerships with local housing authorities to provide housing assistance. We are bearing more of the cost and effort in the first 60 days of working with a member, and we don't really see savings until someone is in stable housing for 10 months and longer. There's a balance of where we place the funding while ensuring that goals are aligned; it required working with CHS to understand core barriers to housing placement and developing a discretionary budget that enables CHS to address those needs with program funds. This has led to more members successfully finding a place to call home.

In the program's current iteration, we added funding to meet any member's health-related social needs, such as stocking a refrigerator with healthy food and providing furnishings; we created flexibility in the budget and contract for CHS to do this. Additionally, we budgeted for ongoing monthly costs so that there were funds to support each member on a per month basis. It is important to make sure incidental costs are built into the budget and to minimize the need for community partners to draw support from philanthropic sources.

In our current version of the contract, we have moved to a performance-based agreement: the anticipated savings from reductions in unplanned health care utilization as a result of stable housing is used to provide incentives and bonus payments to CHS for the elements of the housing process that they can control, which in turn allows CHS to reinvest in its housing programs. For example, we offer incentives for faster move-in, longevity bonuses, and graduation bonuses for CHS if a member no longer needs housing support.

We're really happy with this latest version of the contract, but it went through many iterations to make certain we were meeting the member's needs and ensuring CHS had the funding needed to support members and align incentives. We also brought in a third party to define the aligned goals of both organizations and ensure the contract language promoted successful outcomes for participants.

EXCHANGE OF DATA & INFORMATION

Q: How do you exchange data and information about the members? Has that been a challenge?

Exchanging data has not been a challenge, as we have a Business Associate Agreement in place and follow usual HIPAA compliance regulations. While CHS uses its own case management system and UPMC Health Plan has its own health information technology infrastructure, CHS can receive data downloads from UPMC's system—they just can't access it in real time. Additionally, because we communicate and work so closely to help our members, our text notes and systems often have the same information about the member. With that said, we have started to discuss what it might look like to link our data sources. That's an ongoing conversation and requires ensuring that we're meeting each partner's information-sharing needs.

UPMC has a data-sharing agreement with the county Department of Human Services that allows us to see which human service programs UPMC Health Plan members use and to exchange service coordinator information to improve care management. CHS has its own internal database, but also uses the HUD Homeless Management Information System, which can be accessed through a client view to see connections in the housing realm and at the county level, so we can advocate for members through that system as well.

Q: Are there any other challenges that you overcame? Is there a key to your success?

None of this work is possible without the county. CHS relies on the ability to braid UPMC Health Plan's funding with HUD subsidies available through the local housing authorities and the county's Continuum of Care program.

In terms of barriers, when we were first starting we had conversations with the county on the Continuum of Care program, which is an annual grant from HUD to help homeless individuals. Continuum of Care funds are limited and in demand, and the housing authorities' willingness to work with CHS to open up housing choice vouchers to more individuals in need has been invaluable. As we think about the scalability of the program and taking it to different markets, the first question we want to ask ourselves is: How can we partner with local governmental partners to fully optimize available housing assistance funds?

Success really comes down to having a partner who is deeply involved in the overall strategy of stabilizing the member's health and housing needs and who advocates on behalf of the member. We use a housing first and harm reduction philosophy in our work, and it's been important to have that unified vision between both UPMC Health Plan and CHS.

Also crucial is maintaining the willingness to support additional partners to address related upstream issues. One current pilot program enables Pittsburgh's redevelopment authority to provide below-market rate loans to landlords operating less than five rentals who are willing to accept Housing Choice Vouchers. To qualify, the landlords will need a recent inspection from the housing authority and agree to lease units to low-income households for multiple years. This is an innovative approach that aims to improve 50 units in the first year and could prove an effective strategy in reducing the overall deficit of 20,000 affordable units in Pittsburgh. To the

extent possible CHS will connect landlords in their network with this program, and in turn, improve the quality of members' home.

Funding the Program

Q: How do you fund this program?

It is currently funded through UPMC Health Plan's administrative dollars, but beginning in January 2021, UPMC Health Plan will be able to include program expenses in our medical expenditure reporting rather than as an administrative cost. That means these costs are included in the rate setting process in future years.

Next Steps & Future Opportunities

Q: What are next steps for this program?

We'd like to replicate this program in other jurisdictions and increase the numbers of individuals receiving housing support. We're hoping to increase the number of members served by 30 to 40 this coming year and 250 members over the next couple of years.

Q: Is CHS also planning to increase their staff size to meet this growing program?

From the beginning, we decided to keep a range of 30-35 clients per case worker and when we hit that number we need to hire. That's where we are now. We have two social workers within the program, but one was promoted and so we are replacing her position and then hiring a third social worker.

*Interview has been edited for length and clarity.

ABOUT NORC MEDICAID MCO LEARNING HUB

The key goal of the NORC Medicaid MCO Learning Hub is to serve as a source of information, expertise, and best practices to support managed care organizations in moving forward with system reform. NORC and its partner organizations identify, develop, and disseminate promising approaches and emerging opportunities for MCOs to improve the physical health, behavioral health, and social needs of their members.

Your ideas and opinions are important to us. We welcome your feedback on future Medicaid MCO Learning Hub work or programs you are working on to better serve your needs.

We want to hear from you. Please contact us at MCOLearningHub@norc.org to start the conversation or join our distribution list.

www.norc.org/Research/Projects/Pages/medicaid-managed-care-organization-learning-hub.aspx

Acknowledgements

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For more information on the partnership between UPMC Health Plan & CHS listen to the following "Good Health, Better World" podcast episode: Season 1, Episode 4: How a Home Helps Your Health | The Postindustrial

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