

# Housing Options for High-Need Dually Eligible Individuals: Health Plan of San Mateo Pilot

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## IN BRIEF

Many individuals with long-term services and supports (LTSS) needs either reside in institutions or are at risk for institutionalization. Rebalancing care to provide LTSS in the community is one goal of the federal Financial Alignment Initiative for Medicare-Medicaid enrollees. This profile details the experiences of the Health Plan of San Mateo (HPSM), a participant in California's Cal MediConnect financial alignment demonstration, as it implements a pilot program to help dually eligible individuals in nursing facilities transition back to community living and those at risk of nursing home placement to remain in the community. Lessons from this pilot may help other health plans, states, and providers develop approaches to serving dually eligible individuals with extensive LTSS needs. HPSM is a participant in *PRomoting Integrated Care for Dual Eligibles* (PRIDE), a national initiative made possible by The Commonwealth Fund.

More than 40 percent of Medicare-Medicaid enrollees experience functional limitations due to chronic physical and behavioral health conditions and, as a result, require long-term services and supports (LTSS).<sup>1</sup> Approximately two-thirds of these individuals receive LTSS in their homes or other community-based settings, while the other third reside in institutions.<sup>2</sup> States and health plans across the country are exploring opportunities created or extended by the Affordable Care Act, such as flexibilities in funding offered in the federal Financial Alignment Initiative and the Balancing Incentive Program, to help Medicare-Medicaid enrollees either avoid institutionalization or return to the community, thus achieving higher quality of life and reducing costs.

The Health Plan of San Mateo (HPSM), a non-profit public health plan that covers more than 140,000 residents of San Mateo County, California, is one of 10 health plans serving dually eligible individuals in Cal MediConnect—California's capitated demonstration program under the Financial Alignment Initiative.<sup>3,4</sup> In 2014, HPSM implemented the Community Care Settings Pilot program (the pilot), which is designed to avoid institutionalization of dually eligible members and to transition individuals from institutions back to community living. The five-year pilot aims to connect more than 800 members with housing and care coordination services. A phased approach, overseen by a care manager, supports members to ensure successful transitions to the community. This profile highlights the design and implementation of HPSM's pilot, which may be a useful model to promote independent community living for dually eligible individuals.

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## Building the Pilot

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In designing its five-year pilot, HPSM partnered with two non-profit organizations, the Institute on Aging (IOA) and Brilliant Corners (BC).<sup>5</sup> IOA provides intensive transitional case management and oversight, and BC is a housing agency that establishes supportive housing communities and transitions at-risk individuals from institutions or homelessness to stable, community-based residences.<sup>6</sup> The pilot also relies on HPSM's partnerships with organizations operating in San Mateo County, including: affordable supportive housing providers; county agencies (e.g., Aging and Adult Services and Behavioral Health and Recovery Services); hospital and nursing facility discharge planners and social workers; and a network of community Residential Care Facilities for the Elderly.<sup>7</sup>

Depending on an individual's unique circumstances, the pilot taps into different housing sources, including: the individual's existing home; affordable supportive housing; scattered-site housing; and assisted living.<sup>8</sup> HPSM leverages an array of funding sources, such as the Money Follows the Person demonstration, state waiver programs, the flexibility of California's Cal MediConnect demonstration, and the health plan's own reserves, to pay for the pilot.<sup>9</sup> Financing to keep individuals in the community and aid in transitions comes from local funding and state programs such as the Assisted Living Waiver, as well as LTSS funding incorporated in Cal MediConnect (adult day health care and personal care services, which are called Community Based Adult Services and In-Home Supportive Services (IHSS) in California). Care Plan Optional services, made available through Cal MediConnect, are also used when appropriate.

Over the five-year pilot, HPSM aims to connect more than 800 individuals with housing and care coordination services. HPSM will measure the pilot's impacts on members' health, quality of care, and costs.<sup>10</sup> An evaluation will examine the volume of members served, member satisfaction, health outcomes, service utilization, the success of housing placements, and cost savings.<sup>11</sup>

## Selection Criteria

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To achieve the greatest likelihood of long-term community placements, HPSM developed criteria to identify the best candidates for participation. These criteria consider not just functional status, but also the individual's desire to move, his or her social support system, the availability of appropriate services in the community, and whether or not the individual could safely and successfully live in the community.

HPSM targets individuals who:

1. Reside in long-term care settings who could transition to lower levels of care;
2. Are about to be discharged from acute care hospital stays and need LTSS; and/or
3. Currently live in the community, but are at risk of hospitalization or admission to a long-term care facility.

Eligible individuals are identified via an intake form through various sources, including: skilled nursing facility (SNF) staff; HPSM case managers; hospital discharge planners; high-utilizer reports; county agency case managers; supportive housing managers; social service programs; and primary care providers. A case-mix indexing tool, developed by the HPSM, IOA, and BC pilot team, helps to prioritize targeting of individuals for inclusion in the pilot (exhibit 1). Once initial eligibility is determined, candidates are assessed in-person by an IOA case manager. The case manager prepares a case summary and proposed care plan that is presented to the Pilot Core Group, which includes representatives from San Mateo County's behavioral health and aging and adult services agencies, BC and IOA, HPSM staff representing multiple functional areas, and also the individual and his/her family as appropriate.

EXHIBIT 1: HPSM Pilot Case-Mix Indexing Tool\*\*

Best Case Scenario (10-12 points)

SNF Resident				
LINE OF BUSINESS	TARGET POPULATION	PRIORITIZATION FACTORS		TOTAL POSSIBLE POINTS
Cal MediConnect or Care Advantage +3 points	SNF Resident +3 points	<ul style="list-style-type: none"> <li>Primary barrier to discharge is housing +1 point</li> <li>Expressed preference and motivation to return to the community +1 point</li> <li>Behavior unlikely to jeopardize potential placement +1 point</li> <li>Client income source expected to support community living +1 point</li> <li>Formal or informal supports motivated to assist client +1 point</li> <li>Current placement is greater than 90 days +1 point</li> </ul>		Cal MediConnect or Care Advantage <b>12 points</b>
Medi-Cal only +1 point				

SNF Diversion				
LINE OF BUSINESS	TARGET POPULATION	PRIORITIZATION FACTORS		TOTAL POSSIBLE POINTS
Cal MediConnect or Care Advantage +3 points	SNF Diversion +2 points	<ul style="list-style-type: none"> <li>Primary barrier to discharge is housing +1 point</li> <li>Expressed preference and motivation to return to the community +1 point</li> <li>Behavior unlikely to jeopardize potential placement +1 point</li> <li>Client income source expected to support community living +1 point</li> <li>Formal or informal supports motivated to assist client +1 point</li> <li>Risk score is greater than 75th percentile of HPSM members +1 point</li> </ul>		Cal MediConnect or Care Advantage <b>11 points</b>
Medi-Cal only +1 point				

Alternative Scenario (8-10 points)

Community				
LINE OF BUSINESS	TARGET POPULATION	PRIORITIZATION FACTORS		TOTAL POSSIBLE POINTS
Cal MediConnect or Care Advantage +3 points	Community Diversion +1 points	<ul style="list-style-type: none"> <li>Current housing at risk and/or accessibility issues identified +1 point</li> <li>Recent history of missing multiple primary or specialty care appointments +1 point</li> <li>Recent history of lack of engagement with service providers +1 point</li> <li>Case management needs exceed those available in community +1 point</li> <li>Formal or informal supports motivated to assist client +1 point</li> <li>Risk score is greater than 75th percentile of HPSM members +1 point</li> </ul>		Cal MediConnect or Care Advantage <b>10 points</b>
Medi-Cal only +1 point				

\*\* A higher number of points indicates greater potential for inclusion in the pilot.

The group convenes via biweekly in-person meetings, where each case is either approved for implementation, modifications to the care plan are proposed, or the individual is deemed ineligible and alternative services and supports are recommended. Decisions are made by consensus and all Pilot Core Group members are encouraged to openly share their thoughts on all cases. As a result, a case manager or agency representative is as likely to influence the final decision as an HPSM medical director.

## Transition to the Community and Phased Services to Support Community Living

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Once a dually eligible member is identified for the pilot, the process of safely transitioning the individual to the community and connecting him/her with appropriate services and supports begins. The IOA case manager leads this process, which typically takes from three to six months depending on the intensity of the individual's needs and includes "pre-transition" work before an individual is discharged. During this period, the IOA case manager meets regularly with the member and any stakeholders involved in that individual's care such as family, physicians, other providers, or social workers. HPSM uses a variety of approaches when transitioning an individual based on that member's initial residence and projected care needs. For all individuals requiring residential services, the Pilot Core Group determines the least restrictive community housing option that is likely to succeed (e.g., assisted living facilities, affordable housing, or scattered site housing). Then the IOA case manager either works with a contracted assisted living facility operator or coordinates with BC to identify available affordable housing and rental subsidy information.

Individuals participating in the pilot face different challenges depending on their current living situation. For long-term care (LTC) and SNF residents, getting services connected and arranging prescription medications before discharge are often a challenge. Many programs and services such as IHSS<sup>12</sup> are not currently configured to allow this type of advance coordination, so case managers must work harder to arrange transitions for LTC and SNF residents. Despite such challenges, HPSM has found that between 10 and 30 percent of existing LTC residents are able to safely move to lower levels of care, often because the real reason for institutionalization was for housing or social reasons, not clinical or functional status needs.

Individuals residing in the community may also need a wide range of services and supports to maintain or extend independence. Challenges for community-dwelling participants may include a landlord dispute, a Section 8 voucher expiring during a hospitalization, or a home that is no longer safe and accessible given the individual's functional status. BC is typically able to remedy these problems. IOA also works with members to implement additional supportive services such as IHSS, nutrition services, transportation assistance, or other programs that ensure the individual can live in the community.

Once an individual is transitioned to the community and connected to services, there is an evaluation period to ensure that the placement and/or implemented services are effective for the individual and likely to allow him or her to continue to reside in the community over the longer term. When a member has stabilized, IOA transitions him or her to a less intensive, but ongoing case management program through HPSM or county agencies. Regardless of the transition of IOA case management services, BC will remain connected to members requiring housing services throughout the pilot and support them as a landlord liaison, emergency contact, light-touch case manager (habitability and wellness checks), along with other roles.

## Keys to Success

The HPSM pilot uses phased services to promote independence among members who are transitioning to community living. IOA provides highly intensive care management and values strong connections with the member to ensure successful transition to the community. Case managers maintain close relationships with participating members, at a 1:20 or lower ratio, to develop comprehensive service plans that meet member goals. Case managers have defined goals within three stages of the member’s first year in the community (exhibit 2).

**EXHIBIT 2: Case Manager Monthly Goals after Members Transition to the Community**

Phase	Timeframe	Goals
Transition	1 - 3 months	<ul style="list-style-type: none"> <li>■ Successful discharge from institutional setting</li> <li>■ Connections made to community services</li> <li>■ Frequent home visits by case manager</li> <li>■ Primary care provider involvement verified</li> </ul>
Try Out	4 – 6 months	<ul style="list-style-type: none"> <li>■ Problem solving and other skills developed</li> <li>■ Regular contact with case manager</li> <li>■ Crisis intervention as needed</li> </ul>
Transition Phase	7 – 12 months	<ul style="list-style-type: none"> <li>■ Unmet goals resolved</li> <li>■ Ensure member independence and success</li> <li>■ Transfer of services from IOA to HPSM case manager</li> </ul>

As the individual’s needs change over time, HPSM adjusts care plans and services accordingly. By promoting an approach based on member self-determination,<sup>13</sup> HPSM has recognized that many participants quickly developed the ability to manage their own affairs as they adjust from the fully supportive environment of an institutional setting. Ongoing adjustment and phasing of services allows the individual to remain safe and independent in the community.

### HPSM’s Community Care Settings Pilot in Action<sup>5</sup>

Jim is a 58-year-old, single male who was admitted to a SNF in September 2014 for rehabilitation following knee replacement surgery. He had a long history of homelessness prior to admission and had no home to go to after discharge. Jim had a history of alcohol abuse and had been to a residential alcohol and drug rehabilitation program. He also had multiple suicide attempts and voluntary psychiatric hospitalizations. After evaluation by HPSM’s interdisciplinary team and the Pilot Core Group, he was approved for a scattered site housing unit and moved into it in March 2015. Jim returned to Alcoholics Anonymous meetings, which he continues to attend. Since being housed through the HPSM pilot, Jim has also reconnected to behavioral health services and is complying with psychiatric treatment. He has not had any relapses or suicide attempts and has started riding his bike to regain his strength. His family visits with him regularly, and Jim reports that he loves his new home.

<sup>5</sup> The member’s name and other identifying details have been changed to protect confidentiality.

## Successes to Date and Future Plans

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As of January 2016, HPSM's pilot transitioned 70 individuals to community settings. As noted earlier, HPSM expects to serve more than 800 individuals over the five-year pilot. Successful elements of the pilot will be integrated into HPSM's care management program for individuals at risk of SNF placement.<sup>14</sup> Initial data collected by HPSM are promising and show high member satisfaction with services, reduced health care service use, and stable community placements. HPSM will continue to track these and other metrics to evaluate pilot successes and justify the extension of select services and supports to broader at-risk populations.

The Community Care Settings Pilot is an example of the emerging success stories resulting from increased flexibility in funding and service delivery for Medicare-Medicaid enrollees being developed by plans, states, and their federal partners. These efforts are helping more individuals to live in the community, thereby promoting a higher quality of life and lower costs of care.

### ACKNOWLEDGMENTS

Thank you to the staff at Health Plan of San Mateo for sharing their efforts to improve the lives of individuals dually eligible for Medicare and Medicaid – Maya Altman, Ed Ortiz, Chris Esguerra, MD, and Preston Burnes. The authors also extend thanks to The Commonwealth Fund for its support and encouragement in the spread of promising models of care delivery for dually eligible individuals.

### ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit [www.chcs.org](http://www.chcs.org).

This spotlight is a product of *PRomoting Integrated Care for Dual Eligibles* (PRIDE), a CHCS national initiative supported by The Commonwealth Fund.

## ENDNOTES

<sup>1</sup> United States Congressional Budget Office. "Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, 2013." June 2013. Available at:

[https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/44308\\_DualEligibles2.pdf](https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/44308_DualEligibles2.pdf).

<sup>2</sup> The Kaiser Family Foundation. "What Would Strengthen Medicaid Long-Term Services and Supports?" August 2013. Available at:

<http://kff.org/medicaid/issue-brief/testimony-what-would-strengthen-medicaid-long-term-services-and-supports/>.

<sup>3</sup> HPSM serves individuals dually eligible for Medicare and Medicaid through a Dual-Special Needs Plan (D-SNP), and a Medicare-Medicaid Plan (MMP). As of January 2016 HPSM had 788 members through its D-SNP and 9,718 through its Cal MediConnect MMP.

See: Centers for Medicare & Medicaid Services. SNP Comprehensive Report. January 2016. Available at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDENrolData/Special-Needs-Plan-SNP-Data-Items/SNP-Comprehensive-Report-2016-01.html?DLPage=1&DLEntries=10&DLSort=1&DLSortDir=descending> and Integrated Care Resource Center

"Monthly Enrollment in Medicare-Medicaid Plans by Plan and by State, January 2015 to January 2016." Available at:

<http://www.chcs.org/media/ICRC-MMP-Enroll-by-State-January-2016.pdf>.

<sup>4</sup> For more information see: <https://www.hpsm.org/abouthpsm/mission.aspx> and <https://www.hpsm.org/abouthpsm/members.aspx>.

<sup>5</sup> For more information see:

<http://www.ioaging.org/services/all-inclusive-health-care/community-care-settings-pilot-program> and <http://brilliantcorners.org/>.

<sup>6</sup> Response to Health Plan of San Mateo County's Community Care Settings Request for Proposal, Institute on Aging and West Bay Housing, April 2014.

<sup>7</sup> E. Ortiz. "Extending Health Care into Community Settings: HPSM Community Care Settings Pilot." Health Plan of San Mateo presentation, January 2015.

<sup>8</sup> E. Ortiz. "Housing and Health: Lessons Learned So Far." Health Plan of San Mateo presentation, February 2015.

<sup>9</sup> Memorandum from Maya Altman, Chief Executive Officer and Edward Ortiz, Director of Provider Network Development and Services, Health Plan of San Mateo, to San Mateo Health Commission, August 2014.

<sup>10</sup> E. Ortiz. January 2015, op cit.

<sup>11</sup> Memorandum from Maya Altman, op cit.

<sup>12</sup> IHSS provides homecare services to Medi-Cal-eligible, aged, blind, or disabled individuals to help them remain in their own homes. Services include: preparing meals; bathing; dressing; laundry; shopping; transportation; wound care; and protective supervision. For more information see: <http://smchealth.org/ihss>.

<sup>13</sup> Response to Health Plan of San Mateo County's Community Care Settings Request for Proposal, Institute on Aging and West Bay Housing, April 2014.

<sup>14</sup> Request for Proposals, Community Care Settings Pilot. Health Plan of San Mateo, October 2013.