January 13, 2016
Community HealthChoices
MCO Meet and Greet
Hilton Harrisburg
County Services and Structure

Community Health Choices Managed Long-Term Services and Supports MCO/County Meet and Greet
January 13, 2016
County Human Services
General Information

- Human Services programs account for up to 60 percent of county budgets

- Decisions impacting the funding, administration, planning and delivery of human services are a critical component of county government.
Human Services System Structures

- HS structure varies among counties as commissioners or council members choose an administrative structure for HS that most effectively addresses their community needs

- 3 Main County Human Services Structures in PA
  - Departments that have a HS director with oversight of multiple departments including the categorical services such as Children & Youth, Drug & Alcohol, Mental Health, etc.
  - Departments with a HS director that has coordination responsibilities but no oversight of categorical services
  - Systems where there is no HS director for oversight or coordination purposes and county agency directors report directly to chief clerks, county administrators, and/or commissioners
Human Services System Structures Continued

- About half of Pennsylvania counties have a structure that includes a HS director with oversight of categorical and community services.

- 15 counties have an administrative structure that includes HS directors with coordinating responsibilities, these directors have oversight of HS aspects like transportation, information and referral, housing, and adult community services.

- HS staff is tasked with designating programs and services that fill gaps in the system where individuals may not qualify for funding through specific categories or where needs overlap several categorical programs.
Funding

- The Human Services Developmental Fund (HSDF) is administered at the state level through DHS and provides all counties with flexibility to use dollars for various HS related programs.
- 30 counties participate in the Human Services Block Grant that provides even greater flexibility to move funds between HSDF, mental health and intellectual disability base funds, and Act 152 Drug and Alcohol funds in order to best meet local needs.
- Other funding sources include Homeless Assistance Program and Medical Assistance Transportation Program.
Community Behavioral Health
1966 Community Mental Health and Intellectual Disability Act

- Grant Program (*state funds with some services having 10 percent county match*)
- No entitlement
- County Specific Responsibilities (Article III) (48 County/Joinders)
- Mandated Services
Mandated Services

- Short term inpatient services other than those provided by the State
- Outpatient services
- Partial hospitalization services
- Emergency services twenty-four hours per day
- Consultation and education services to professional personnel and community agencies
Additional Mandated Services

- Aftercare services for persons released from State and County facilities
- Specialized rehabilitative and training services including sheltered workshops
- Interim care of intellectually disabled persons who have been removed from their homes and who having been accepted, are awaiting admission to a State operated facility
- Unified procedures for intake for all county services and a central place providing referral services and information
Additional Community Services – Base Dollar Funding

- Supported Housing
- Forensics Initiatives
- Evidence Based Practices Developed within MA System (Peer Supports, Psychosocial Rehab)
Medicaid Behavioral HealthChoices

- Began in 1997 and statewide 2007
- Recognition of 1966 Community MH/ID Act
- County Mandate
- Goal to unify service development and financial resources at the local level
County Right of First Opportunity

- Counties were offered to do managed care locally.
- Counties could join together to contract for managed care.
- Counties could default to the state to implement managed care.
- All contracts would meet the same federal and state standards.
Configuration of Contracts (67 counties)

- State Contract Oversight
  - 23 counties in north central Pennsylvania (BHARP)
  - Greene County

- Single County Contract – 15
- Multi-County Contract – 28
PACDAA
The Pennsylvania Association Of County Drug and Alcohol Administrators (Single County Authorities)

Forty-seven SCA’s provide services in all sixty-seven counties

SCA’s receive state and federal dollars from the Pennsylvania Department of Drug and Alcohol Programs (DDAP)

SCA’s also receive treatment funding from the Department of Human Services (DHS)
PACDAAA recognizes the need for and importance of ensuring that:

- care is managed adequately
- Taxpayer dollars are used effectively and efficiently
- Community based support is available for a client’s continued recovery
- Treatment and environmental and social supports are available to enhance continued recovery
- Comprehensive community-based prevention programs that empower and mobilize citizens are provided
Four Organizational Models

- Planning Council
  - County establishes the SCA as part of Mental Health Intellectual Disabilities Program

- Executive Commission (Public)
  - County establishes department within county government to deliver substance abuse services

- Executive Commission (Private)
  - County contracts with non-profit to provide substance abuse services

- Independent Commission
  - Private entity contracts directly with Commonwealth for substance abuse services
Preparing for Community HealthChoices
Behavior Health HealthChoices Overview

Deborah Wasilchak, Community Care
Joan Erney, Community Behavioral Health
Jim Leonard, Magellan Behavioral Health
BH HealthChoices Partnerships

• Pennsylvania Department of Human Services (DHS)
• County Behavioral Health/Human Services
  – Primary Contractor
  – Alliance of Counties
• Behavioral Health MCOs
  – Primary Contractor
  – Administrative Services
  – Subcontracted managed care partner
Role of DHS and OMHSAS

• Monitor BH MCO performance in meeting HealthChoices program standards and requirements:
  – Monitoring team meetings
  – Ongoing reporting requirements
  – Quality management oversight
  – Annual review process

• Further HealthChoices program development
Role of County HealthChoices

• Visionary leadership to support the ongoing development of the local HealthChoices program

• Integrated approach to meeting member needs
  – Ease of access to services
  – Effective management of Medicaid and county funded services
  – Joint service development to address gaps
  – Furthering integrated care management

• Local oversight and management of the program
Role of BH MCOs

- Meet program standards and requirements
- Perform delegated managed care functions
- Be a responsive and accountable partner to counties
- Bring state-of-the-art information technology used to further the aims of the program
- Demonstrate fiscal accountability
- Collaborate with human services, providers, members, and cross-systems coordination
- Bring innovation, promote clinically competency, and recovery focused care
- Provide specialized care management for individuals with complex needs, including coordination of care with community-based services
BH MCO Critical Functions

- Member Education & Outreach
- Community Relations
- Customer Services
- Care Management
- Utilization Management
- Quality Management
- Outcomes Management
- Program Development
- Network Management
  - Service Access
  - Credentialing
  - Contracting
- Training
- Claims Processing
- IT
- Finance
Focus on Recovery

Improving the Well-Being of the Individual and the Community

Person with Lived Experience

- Recovery Transformation
- Peer & Family Involvement
- Respecting Individual Differences
- Physical & Behavioral Health Integration
- Focused Care Management Model
- Systems Integration (Children & Youth)
Background

68% of adults with mental health (MH) conditions also have medical conditions

- People with MH conditions: 25% of adult population
- 68% of adults with mental health conditions also have medical conditions
- 29% of adults with medical conditions have mental health conditions
- People with medical conditions: 58% of adult population
Background

• Social determinants and modifiable lifestyle factors are key contributors to medical status

• Increased morbidity & mortality associated with SMI
  – Largely due to preventable medical conditions: metabolic disorders, cardiovascular disease & high prevalence of modifiable risk factors (i.e., obesity, smoking)

• Traumatic stress exposure can lead to both mental & medical illness

• Co-morbid substance abuse can increase medical illness
Accessing Behavioral Health Services
Available Services

State Plan Services

Mental health
• Inpatient
• Partial hospital
• Outpatient
• Case management
• Peer specialists
• Crisis Services

Substance abuse
• Inpatient Detoxification
• Inpatient Rehabilitation
• Partial hospitalization
• Outpatient

Supplemental Services

• Assertive Community Treatment (ACT) Teams
• Enhanced Team Models
• Mobile Medication Teams
• Psychiatric Rehabilitation
• Dual Diagnosis Treatment Teams
• Recovery Specialists
• Halfway house
Ease of Access

- County Assistance Office determines MA eligibility
- Individual enrolled with BH MCO serving home county
- No wrong door for most ambulatory services
- Case Management for those with serious mental illness or complex needs
- Focus on care coordination when transitioning from inpatient levels of care
  - Care management presence on units
  - Coordination with PH Special Needs Units
- Electronic or telephonic auth processes for providers
Care Management Overview

• Team of licensed and specialty clinicians:
  – Collect and review clinical information
  – Assess medical necessity; authorize services
  – Consult with physicians as needed
  – Ensure coordination and continuity of care
  – Promote the full participation of the member and family in treatment plan development
  – Assess provider adherence to performance standards
  – Participate in interagency team meetings
High Touch Care Management

• Interview with individuals before leaving the hospital supporting access to needed services

• Supports and linkages needed for community tenure

• High Risk Care Management Training
  – Training in Motivational Interviewing
  – Clinical knowledge of high risk member
  – In person treatment team attendance
Care Management Interventions

• Follow up occurred with the inpatient treatment team to ensure:
  – Linkage to aftercare providers
  – Linkage to housing supports; food banks; transportation; assistance with ADL’s
  – Linkage to higher level of community supports such as:
    • Acute Service Coordination
    • Mobile Medications
    • Community Treatment Team
    • Diversion and Acute Stabilization Units
    • Drug and Alcohol Rehabilitation Programs
Focus on Integrated Care: Examples of Initiatives
Rethinking Care SMI Projects

• Initiative to improve the connection and coordination of care for those with SMI among health plans, PCPs, and BH providers in outpatient, inpatient, and ED settings

• Based on Patient-Centered Medical Home model with integrated care team and care plan to address all medical, behavioral, and social needs

• Partnership between:
  – Center for Health Care Strategies (CHCS)
  – Pennsylvania Department of Public Welfare (DPW)
  – PH MCOs
  – BH MCOs
  – Counties
  – Primary project was individuals on Medicaid only; implementation also included dual eligible members
Key Interventions

- Information sharing of urgent events with providers
- Creation of a shared data view between PH and BH MCOs
- Joint care management meetings with inclusion of provider as indicated
- Education of PH and BH care managers (CMs) about each other’s systems
- Engagement of members in service planning
- Stakeholder advisory group
- Use of Health Navigators
Rethinking Care Summary

• Steps toward integration can contribute to reducing excessive ED use & MH hospitalizations

• PCPs valued receiving previously unavailable clinical support & information about members

• Exchanging PH/BH information was critical for a holistic approach to care

• Privacy issues surrounding information exchange were critical to address

• BH systems can be a natural point of provider & member engagement & care coordination for individuals with SMI
Behavioral Health Home Plus (BHHP)

• Designed to demonstrate the efficacy of care coordination of PH/BH services for individuals with SMI & co-occurring medical conditions

• Successful collaboration with BH providers in PA over the past five years:
  – Creating a health home in BH agencies
  – Development of a wellness culture through wellness coaching training
  – Case managers, certified peer specialists, and nurses as health navigators
  – Web portal with wellness tools and resources
BHHP Model

• Provide a person-centered system of care
• Development of a “virtual team” for each individual
• Enhance PH competencies in the BH team
• Develop person-centered plan with the individual
• Coordination of physical, behavioral, and supportive services
• Reporting
• Promote health, wellness, recovery, use of personal medicine, and self-management
PA Housing Landscape:

And you thought MCO’s were complicated...
"Do you ever get to the point where you think if you read another book you'll burst, but you do anyway, and you don't burst?"

TUESDAY JANUARY 31
• Created in 1972

• To finance affordable apartments and homes for older adults, low and moderate income families and people with special housing needs

• At minimal expense to the Commonwealth

• Outside of the state budget system

• Raise revenues by selling taxable and tax-exempt securities
3 Major Areas of Operations:

- **Homeownership** financing - $12 billion / 160,000 households

- **Foreclosure** abatement – saved nearly 50,000 families from foreclosure

- **Rental housing** financing – financed the construction or rehabilitation of > 129,000 rental units
PA Housing Landscape

- Housing affordability
- Age of PA population
- Age of PA housing stock

Trending up or down???
Hours needed at minimum wage to afford a one-bedroom unit

Source: CityLab May 27, 2015
Pennsylvania

Senators: Patrick J. Toomey and Robert P. Casey, Jr.

Many renters in Pennsylvania are extremely low income and face a housing cost burden. Across the state, there is a deficit of rental units both affordable and available to extremely low income (ELI) renter households, i.e., those with incomes at 30% or less of the area median income (AMI).

Last updated: 9/15/15

HOUSING COST BURDEN BY INCOME GROUP

- Renter households spending more than 30% of their income on housing costs and utilities are cost burdened; those spending more than half of their income are considered severely cost burdened.

<table>
<thead>
<tr>
<th>Income Group</th>
<th>Cost Burdened</th>
<th>Severely Cost Burdened</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deeply Low Income</td>
<td>95%</td>
<td>91%</td>
</tr>
<tr>
<td>Extremely Low Income</td>
<td>86%</td>
<td>74%</td>
</tr>
<tr>
<td>Very Low Income</td>
<td>73%</td>
<td>28%</td>
</tr>
<tr>
<td>Low Income</td>
<td>6%</td>
<td>38%</td>
</tr>
<tr>
<td>Not Low Income</td>
<td>1%</td>
<td>7%</td>
</tr>
</tbody>
</table>

Source: NLIHC tabulations of 2012 American Community Survey Public Use Microdata Sample (PUMS) housing file.

KEY FACTS

- 31% of Households in Pennsylvania are renters

426,582

Renters in this state

28%

Renter households that are extremely low income

$19,770

Maximum state level income for an ELI household

281,952

Shortage of units affordable and available for extremely low income renters

$17.57

State Housing Wage

The hourly amount a household must earn to afford a two-bedroom rental unit at HUD’s Fair Market Rent

Source: NLIHC tabulations of 2007-2011 Comprehensive Housing Affordability Strategy (CHAS) data.

Source: NLIHC tabulations of 2012 American Community Survey Public Use Microdata Sample (PUMS) housing file.

1000 Vermont Avenue, NW, Suite 500, Washington, DC 20005
WWW.NLIHC.ORG
Renter Affordability
2000

Source: U.S. Census Bureau; U.S. Department of Housing and Urban Development

2006-2010

Percent of Median Renter Income to Rent 2-Bedroom Apartment

>30%

<=30%
% of PA 65+ is trending UP
Old Housing Stock

Median Year Structure Built, by County
Pennsylvania = 1961

Source: U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates
Increase:
- Supply
- Affordability
- Accessibility

High housing costs

High % of population 65+

Old housing stock
PHFA-financed rental developments statewide
> 60 PHFA financed developments within 3 miles of where you are now!
Increase Affordability
Suburban development – 5% aff at 20% AMI

<table>
<thead>
<tr>
<th>Unit Type</th>
<th>Nbr of Units</th>
<th>Gross Rents</th>
<th>Utility Allowance</th>
<th>Contract Rent</th>
<th>Targeted Income Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1BR</td>
<td>12</td>
<td>$615</td>
<td>$130</td>
<td>$485</td>
<td>50</td>
</tr>
<tr>
<td>2BR</td>
<td>8</td>
<td>$738</td>
<td>$173</td>
<td>$565</td>
<td>50</td>
</tr>
<tr>
<td>2BR</td>
<td>8</td>
<td>$738</td>
<td>$173</td>
<td>$565</td>
<td>50</td>
</tr>
<tr>
<td>6</td>
<td>2BR</td>
<td>$886</td>
<td>$173</td>
<td>$713</td>
<td>60</td>
</tr>
<tr>
<td>3</td>
<td>2BR</td>
<td>$738</td>
<td>$173</td>
<td>$616</td>
<td>60</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>60% of Median Income</td>
</tr>
<tr>
<td>1</td>
<td>2BR</td>
<td>$886</td>
<td>$173</td>
<td>$713</td>
<td>60</td>
</tr>
<tr>
<td>2</td>
<td>2BR</td>
<td>$738</td>
<td>$173</td>
<td>$616</td>
<td>60</td>
</tr>
<tr>
<td>1</td>
<td>3BR</td>
<td>$886</td>
<td>$173</td>
<td>$713</td>
<td>60</td>
</tr>
<tr>
<td>8</td>
<td>3BR</td>
<td>$1,023</td>
<td>$174</td>
<td>$849</td>
<td>60</td>
</tr>
<tr>
<td>2</td>
<td>3BR</td>
<td>$991</td>
<td>$174</td>
<td>$817</td>
<td>60</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Total Units</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>51</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Targeted Income Level</th>
<th>Total Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>20% of Median Income</td>
<td>3</td>
</tr>
<tr>
<td>50% of Median Income</td>
<td>23</td>
</tr>
<tr>
<td>60% of Median Income</td>
<td>25</td>
</tr>
</tbody>
</table>

Financing:
- $2,400,000 Allegheny County - Primary Financing - Local Housing and Community Development Funds
- $300,000 DCED Keystone Community - Secondary Financing - DCED Community Development Grant
- $6,242,807 - Owner's Equity - Owner's Equity
- $337,232 reinvested developer fee - Owner's Equity - Owner's Equity
- $4,862,669 - Owner's Equity - Owner's Equity
Increase Accessibility

- No-step entries
- Single floor living
- Switches & outlets reachable
- Extra-wide hallways & doors
- Lever-style door & faucet handles
Other PHFA Resources

• **PHARE** uses Marcellus Shale impact fee revenue to address affordable housing needs in counties with drilling.

• **PAHousingSearch.com** – free web-based service to list and search for homes and apartments in PA.

• **HOME/NHT TBRA** – rental assistance for people with disabilities and those moving out of nursing homes. NHT TBRA uses PA Dept of Human Services funds.

• Resources for home modifications to achieve energy efficiency or accessibility.

• **PBOA** provides a rental subsidy for people with behavioral health disabilities, funded in several counties with Health Choices Reinvestment Funds.
PHARE

Municipalities with Unconventional Gas Wells
Subject to Impact Fee, as of 6/4/15

- 104 projects funded (128 applied)
- $25.3 Million awarded ($42M requested)
- $191 Million in leveraged funds
- 302 new rental units
- 720 rehab/repair/preservation of homes or units
- 1,594 households w/rental, utility assistance
- 331 vacant properties acquired/demolished
- 77 new single family homes
- 93 households w/downpayment or closing costs
Welcome to PAHousingSearch.com, a free resource to help you find a home that fits your needs and budget. Property providers can list available apartments or homes at any time, which means our listings are current.

Free to list
Free to search
Navigating the Landscape

Public Housing Authorities – county or municipal based authorities with funding directly from HUD
  • Public Housing (buildings)
  • Housing Choice Vouchers (section 8 vouchers)

Non-profit and for profit developers

Regional Housing Coordinators – 11 extremely knowledgeable experts!

Management agents – hired by property owners to run the rental complex

Service Coordinators – on-site

Types of assistance
  • Project-based (stays with the unit) – e.g. HUD bldngs; Section 8 bldgs, Section 202, Rural Development, “old” Sect 811 (bldngs), “new” Sect 811 PRA (units in tax credit bldngs)…
  • Tenant-based (goes with the person) – Housing Choice Vouchers, VASH vouchers for veterans, HOME/NHT TBRA, …
Contact: Carla Falkenstein
PHFA, Director of Western Region
cfalkenstein@phfa.org
412-429-2841
Allegheny County Office of Behavioral Health
Permanent Supportive Housing Program

CHC Managed Care Organization Meet & Greet
January 13, 2016
Allegheny County HealthChoices Medicaid Managed Care Program

Allegheny County Department of Human Services
Office of Behavioral Health
*Contracts w/ PA DHS*

Allegheny HealthChoices, Inc. (AHCI)
*Oversight/Monitoring Entity*

Community Care Behavioral Health
*BH-MCO*
What is AHCI’s Role?

Formed by Allegheny County to monitor the behavioral health services of their HealthChoices Program.

• Monitoring & oversight
• Information systems design & development
• Training & technical assistance
• Business & fiscal analytics
• Implementation of EBPs & fidelity adherence
Permanent Supportive Housing (PSH) is:

- Safe and secure
- Affordable
- Permanent, as long as the tenant pays the rent and follows the rules of his/her lease.

It is linked to support services that are:

- Optional
- Flexible
### How Does PSH Differ From Other Residential Options?

<table>
<thead>
<tr>
<th></th>
<th>Permanent Supportive Housing</th>
<th>Residential Program/Facility (CRRs, LTSRs, PCHs, group homes, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Relationship of Housing to Services</strong></td>
<td>Service participation is encouraged but not required to live in the housing.</td>
<td>Participation in services is required to live in program/facility.</td>
</tr>
<tr>
<td><strong>Choice</strong></td>
<td>People choose their living arrangements. They are not “placed”.</td>
<td>People may or may not have a choice of their living arrangement.</td>
</tr>
<tr>
<td><strong>Permanency and Tenure</strong></td>
<td>Housing is considered permanent. Residents have leases or rental agreements. Landlord/tenant law governs operation of the housing.</td>
<td>Housing may or may not be permanent. Standard landlord/tenant laws do not apply. Tenure in the housing may be related to clinical services.</td>
</tr>
<tr>
<td><strong>Control of Housing and Privacy</strong></td>
<td>Resident controls who has access to his/her housing.</td>
<td>Resident usually does not have control over who accesses the program/facility.</td>
</tr>
</tbody>
</table>
Target Population

Adults with serious mental illness or co-occurring mental illness and substance abuse disorders

Focus on people currently at:

- State Mental Hospitals (SMH)
- County-funded Community Residential Rehabilitation (CRR) programs
- County-funded Long Term Supported Residences (LTSR)
- Inpatient Mental Health (SMH diversions)
PSH Program Components

- Rental assistance
  - Tenant-based
  - Project-based
  (Both following Section 8/Housing Choice Voucher program rules)
- Contingency Funds
- Housing Support Team
Rental Assistance

- Link to Section 8 Voucher program:
  - Person must apply for Section 8
  - Unit inspection for Section 8 “approvability”
  - Rent & rent assistance rules same as Section 8
  - Landlords required to accept Section 8
  - Provide rental assistance until Section 8 Voucher is received.
Contingency Funds

- Accessed through Housing Support Team
- Used for security deposits, utility deposits, essential furniture/household goods, etc.
- Strict monitoring of approvals and utilization of funds
Housing Support Team

- Help people find/get/keep housing
- Manage PSH referrals and waiting list
- Manage the Rental Subsidy Program
- Recruit landlords to participate in the program
- Coordinate with the person’s clinical team to provide comprehensive, coordinated supports and services.
Some 2015 Statistics

• 121 people being served in PSH program as of December 2015
• 14 people received Section 8 Vouchers in 2015
• 7 people moved into HUD-funded buildings in 2015
• The average rental subsidy in 2015 was about $400
Questions?

CONTACT INFO:
Brandi Phillips
CEO
Allegheny HealthChoices, Inc.
bmauck@ahci.org
412-325-1100
Mission Driven Development

Pam Mammarella, Vice President
Supporting the Core Wishes of Seniors

- To stay in familiar surroundings
- To live in their own home in the community
- Access to Transitional Housing
- To maintain autonomy
- To maintain the maximum level of physical, social and cognitive function possible
- Meeting seniors needs where they live

Meeting Senior's Needs Where They Live
Focus on engagement to promote a quality of life that ensures independence in a community setting, comprehensive services, dignity and choices in an environment that promotes comfort & joy.

Engagement That Promotes Independence
Services On Site (SOS)

Currently Serving 2000 lives In 20 Philadelphia Locations

Providing A Safe Place to Call Home + SOS Service Coordination = Timely Access to Community Based Services

Seniors at the Center of Decision Making
A Combination of Funding

- 1000 units in 10 years
- Tax Credits
- Internal rent subsidy – reinvested developer fee
- Annual Contribution Contract (ACC)
- Rental Assistance Demonstration (RAD)
- Project Based Section 8
- Nursing Home Transition Subsidies

The majority of the rental assistance is governed by HUD and the Equal Housing Opportunity – Federal Fair Housing Act

There’s More Than One Answer
Community HealthChoices
MCO Meet and Greet
January 13, 2016

James B. Pieffer, Senior Vice President
Presbyterian SeniorCare

Member of LeadingAge
Who is Presbyterian SeniorCare

Facts-at-a-Glance

- Western PA
  - 56 communities/services
  - 44 locations
  - 10 western PA counties
- Serving more than 6,500 annually
- Approximately 2,200 employees
- First in Pennsylvania and third in the U.S. to earn accreditation by CARF-CCAC as an Aging Services Network
Presbyterian SeniorCare Provides the Following:

We build and deliver a continuum of living and service options for older adults and their families throughout western Pennsylvania.
Presbyterian SeniorCare Provides the Following:

- **Skilled Nursing Communities**
  - 8 communities / 404 beds

- **Personal Care Communities**
  - 7 communities / 795 beds

- **Continuing Care Retirement Communities**
  - 2 communities / 404 units

- **Affordable Housing**
  - 36 communities / 2,020 units

- **Home and Community-Based Services**
  - Dementia Day Care
  - Community LIFE (partnership with UPMC and Jewish Association on Aging)
  - Longwood at Home (Continuing Care at Home)
  - Presbyterian SeniorCare at Home (Medicare HHA and Private Duty)
Presbyterian SeniorCare Housing Portfolio

- HUD 202/236 Senior Housing
- HUD 811-Persons with Disabilities
- Tax Credit Senior Housing

**Philosophy:**
Service enriched housing supports seniors to live with choice and dignity and provides or coordinates services that support aging in place.
Affordable Supportive Housing
(Service Enriched Housing Model)

Importance of Affordable Housing with Services
• PA has thousands of low/moderate seniors in affordable housing—many are dual eligible
  ✓ HUD, public housing, tax credit, and Farmer’s Home programs
• Significant % of senior residents are frail or at risk (typically 2/3) in our Aging Services Network of over 2,000 residents
• A proactive service enriched program has made an impact on this population
• Monitoring, coordination of services and wellness programs have extended the length of stay and quality of life
Affordable Supportive Housing
(Service Enriched Housing Model)

Importance of Affordable Housing with Services (cont.)

• Number of discharges to personal care and nursing homes have decreased dramatically in the past 10+ years
• Many communities have “death” as their #1 reason for discharge due to care coordination and hospice services
• Programs like the “SASH” program in Vermont (Medicare demonstration) show results of proactive care coordination
PSC Service Coordination Program has several key components:

- Well-trained Service Coordinator (BSW, MSW, etc.)
- Nurse Presence (RN experienced in Geriatrics)
- Wellness Programs
  - Physical/Exercise (i.e., Fall Prevention)
  - Activities/Socialization (Avoid Isolation)
  - Spiritual
  - Volunteer Opportunities
  - Education
- Pro-Active Assessment and Service Plans
- Assistance with Eligibility and Program Connection
- Safe Return to Home After Medical Discharge
- Partnerships with Community Providers
Partnerships Include:
- Area Agency on Aging
- Hospital Discharge Planners
- Home Health Agencies
- Pharmacies
- LIFE Programs
- Churches/Community Groups

Look at Supportive Housing from a Public Health, Population Management Prospective.
Make Unit Modifications to Bathrooms, Kitchens, and Doorways to Support Safety.
Look at Technology Opportunities as Appropriate: Personal Response Systems, Medication Reminders, Telehealth (Quality of Life Technology Center, CMU).
• Managed Care Could Look at Affordable Housing as a Placement Opportunity for Members in Nursing or Care Setting (Waiting List Issues).

• Also Explore Opportunities for Prevention, Programs, and Chronic Disease Management.

• MCO in Other States Have Looked at Partnerships with Senior Housing Providers and Even Invested in Tax Credit Housing Development.

• Encourage MCO’s to Look at SASH and Other Successful Programs and Seek Providers with Strong Commitment to Service Coordination and an Aging with Choice and Dignity Philosophy.
• Gloomy WSJ Report on Duals Demo- But listed Service Coordinators and SASH as “Bright Spot” programs.

• Researchers analyzed health care utilization and spending among 8,706 older adults in 507 properties located in 12 communities around the country. More than half (56%) of the residents were eligible for both Medicaid and Medicare.
  
  o The study, funded by the John D. and Catherine T. MacArthur Foundation, was released in November at the Gerontological Society of America’s annual scientific meeting.
Lewin Group/Leading Age Study: Service Coordinators Reduce the Odds of a Hospital Admission by 18%
SASH: Support and Services at Home

• Team of Wellness Nurses and Service Coordinators.
• Three year study showed a lowered growth of Medicare expenditures for early participants.
• The growth of annual total Medicare expenditures for early SASH participants was $1,756 to $2,197 lower than the growth in Medicare expenditures for beneficiaries in 2 comparison groups.
SeniorCare Network and Presbyterian SeniorCare at Home

- Team of Wellness Nurses and Service Coordinators in six HUD 202’s.
- Service Coordinator has frequent contact with residents allowing for targeted interventions
- RN provides in-person coaching on proper medication management, monitors vital signs, and provides self-care counseling and education, seasonal vaccines, collaborates with physicians, follow up upon return from hospital or nursing facility.
SeniorCare Network and Presbyterian
SeniorCare at Home: Lessons Learned

• Fragmentation among services providers and payor types results in poor ongoing care management of residents
• Outreach to residents is key. Cannot sit in a room and wait for them to come to you.
• It takes a long time for residents to trust a provider and open up to them. We found about one year.
• There is a real fear among residents that increased medical problems, declining cognition and increased frailty will result in eviction and a move to a nursing home.
• Clearly define the population you want to target with the program. Examples:
  o Goal to “hotspot” the building and target frequent flyers to the hospital ED
  o Goal to better manage those few residents who are becoming behavioral problems?
Questions?
Contact Information

Jim Pieffer – jpieffer@sri-care.org
Acquired Brain Injury Overview
Continuum of Care

- Injury
- Hospital/Trauma Center
- Rehab Unit/Free Standing Rehab Hospital
- Home without services
- Nursing Facility
- Limited Outpatient Services
- OLTL/LTSS

Post-acute Home and Community Services Brain Injury Program: residential or in the individuals’ homes/communities
Acquired Brain Injury Services in Pennsylvania

- Numerous rehabilitation units within hospitals in PA
- Freestanding rehabilitation hospitals
- 14 post-acute acquired brain injury (ABI) providers in PA
- Majority of ABI providers in PA have over 25 years of experience providing brain injury services and supports
- RCPA Brain Injury Committee represents the provider group which has formed a strong coalition over the years and works collaboratively on all brain injury issues facing the state
Residential Services

- Designed to assist an individual in acquiring the skills necessary to maximize their independence in ADLs/IADLs
- Services focus on home and community integration and engagement in productive activities
- Services foster improvement or stability in function, social performance, and health
- Services are individually tailored to meet the unique needs of each person as outlined in the individual’s service plan
- Delivered in provider owned, rented/leased settings which maintain home-like environments and are located in residential neighborhoods
- Services are community-based; can be therapy focused, transitional, or long-term
- Most providers offer Structured Day treatment services which meet the Commission on Accreditation of Rehabilitation Facilities’ (CARF) Brain Injury and Home and Community Services standards.
- Services provided up to 24 hours/day, 365 days/year
- Settings serving four or more individuals are licensed by Department of Human Services (DHS) as personal care homes (maximum capacity for waiver is eight per residence)
- All residential providers meet CARF Brain Injury and Residential Rehabilitation program standards
Purpose of Original Waivers

• People with disabilities are not always well served by the regular healthcare system because their disability interferes with them getting served
• CMS Waivers allowed States to “waive” the regular requirements of Medical Assistance to be able to provide more appropriate services
• In PA, the majority of individuals with ABI who are receiving brain injury services are receiving services through the following waivers:
  o CommCare (requires a traumatic brain injury diagnosis)
  o Independence
  o OBRA
Unique Characteristics of ABI

• Acquired brain injury (ABI) means that a person who was born with a normal brain “acquired” a disability from injuring their brain through physical trauma, disease, or illness
• Common deficits may impact cognitive functioning like memory and executive skills, physical functioning, behavioral functioning, and emotional functioning
• Anosagnosia, which means lack of awareness of deficits, is common and prevents individuals from recognizing or being able to communicate their needs.
Unique Approach to Working with Individuals with ABI

- Training and education of staff who work with people who have ABI is essential.
- Assessment strategies must be different because they need to include the following:
  - functional assessments and
  - interviews with individuals who know the participants’ functioning well.
- Developing appropriate individual service plans requires individuals with training and education in behavioral, cognitive, and physical rehabilitation and habilitation.
- Certifications are available to ensure competency [e.g., Certified Brain Injury Specialist (CBIS)]
In-home HCBS Ensures a Continuum of Care for Individuals with ABI

Hundreds of individuals with ABI across the state in every Office of Long-Term Living waiver receive in-home services.

- Services are provided in the homes of the individuals who choose to and are able to remain in their own homes, the home of a family member, or with one or two other participants.

- Examples of critical services are rehabilitation therapies which include cognitive rehabilitation therapy, personal assistance services, community integration, and respite care.

- Providers are CARF accredited for Brain Injury Specialty Services and for Home and Community Services and may be licensed and/or approved by the Department of Health or DHS.

- A key to success is staff with expertise on brain injury generally and trained specifically on the participant’s cognitive, behavioral, and physical needs.

- Uses a combination of specially trained staff (such as cognitive rehabilitation therapists) who can provide structure and direction with follow through by paraprofessionals during non-therapy times. Good coordination and communication are essential.
Focus of Treatment

- Reliance on and coordination with other available services, especially if there are other medical issues (e.g., diabetes, substance use disorders, aging, or physical disability issues)
  - Transportation
  - Adult Day or Structured Day Programs
  - Employment Services
  - Home Modifications and Assistive Technology
  - Durable Medical Equipment
  - Physical Health Care
  - Service Coordination to access these services
- Additional focus on education of paid and natural supports (e.g., direct care workers, family/caregivers, employers, the bank teller, the grocery store cashier) about the participant’s specific needs
- Services are directed at increasing community access, stabilizing psychological and functional status, and prevention of physical and behavioral health regression
- Goals include improving current level of functioning and maintaining the skills that allow them to safely remain in their homes and communities
- Increasing independence while decreasing reliance on family and other natural supports
Challenges and Benefits of In-home HCBS for Individuals with ABI

• Long term nature— slow but steady progress in goal achievement and maintaining function
• Domino effect (e.g., when one thing in their life changes, it upsets the whole applecart, requiring good communication and interventions to deal with the impact)
• Requires an atypical approach to managing care and utilization – it is different than 12 therapy sessions to address an issue whereupon function is restored
• In-home HCBS can be a step in the continuum from higher levels of care to lower
• Can be lower cost than institutional alternatives
• Psychological— increased sense of independence, self-esteem, empowerment
• Long-term effectiveness— participant doesn’t need to generalize skills learned in another setting
• Increases independence while ultimately decreases reliance on informal or paid supports
• Maintains the skills that allow participants to safely remain in their homes
Why CARF?

- CARF is an independent accrediting body of health and human services.
- CARF-accredited service providers have demonstrated conformance to proven standards for business practices and are committed to continuous quality improvement.
- Each provider is evaluated on-site (max accreditation is for three years) and conformance is reconfirmed annually.
- CARF surveyors are practicing professionals in the field and only survey programs for which they have the appropriate expertise allowing for consultation (re: best practices).
- CARF's leading-edge standards are developed collaboratively with involvement of professionals and consumers and are regularly revised due to changes and trends in the field.
- CARF accreditation helps assure financially viable programs, provides consistency across providers, and demonstrates a provider's commitment to continuously improve service quality and to focus on the satisfaction of the persons served.
- CARF accreditation in Brain Injury is a requirement of the 1915(c) Waiver for Residential and Structured Day Services.
CARF and ABI Specialty Programs

- CARF is the only accrediting body to have specific standards for Brain Injury Specialty, Residential Rehabilitation, and Home and Community Services Programs.

- ABI specialty programs must:
  - provide brain injury specific training to its staff and assess competency, and provide education to the persons served and their families;
  - demonstrate how it utilizes current research and evidence to provide effective treatment; and
  - optimize and measure outcomes in functional status, adjustment, inclusion, participation, and prevention.

- Third-party payers, government agencies, and the public at-large recognize the value of a CARF-accredited organization and seek out such facilities.

- Because CARF accreditation signals a provider's demonstrated conformance to internationally accepted standards, it can be used to reduce governmental monitoring and streamline regulation processes.
CARF and Quality

• CARF requires accredited providers to “constantly monitor and assess its performance against a series of performance indicators and targets. Results must be analyzed and result in action plans for improvement as needed.”

• Performance indicators must assess at a minimum: business function, service effectiveness, efficiency, access, and satisfaction.

• Performance targets must be based on an industry benchmark or the organization’s performance history.

• Organizations must have a Strategic Plan & Risk Management Plan, and data from performance indicators must drive decisions and strategy.
CARF and Outcomes

• In 2004, a group of Pennsylvania ABI providers developed a collaborative to measure client outcomes using consistent tools (MPAI-4) and a shared database, allowing for group reporting and peer group comparisons. The group has expanded to include several New Jersey post-acute ABI providers.

• It was the first of its kind in the country and Dr. Jim Malec (co-author of the MPAI), received a federal grant to develop a national database base using the Pennsylvania group model.

• Research analysis of the Pennsylvania/New Jersey data showed that clients in therapy intensive programs make significant progress, despite years post-injury, while clients in long term programs maintain functional status.
About Rehabilitation and Community Providers Association

- Rehabilitation and Community Providers Association (RCPA) is a statewide organization of over 325 members, the majority of who provide services to more than 1,000,000 Pennsylvanians annually.

- RCPA members offer mental health, substance use disorder, intellectual and developmental disabilities, criminal justice, medical rehabilitation, brain trauma, long-term care, and other related human services for children and adults in every setting, including inpatient, outpatient, residential, and vocational.

- RCPA advocates for those in need of human services, works to advance effective state and federal public policies, and provides professional support to members.
RCP-SO Overview

Rehabilitation and Community Providers Services Organization’s Community HealthChoices Managed Care Solution

Rehabilitation and Community Providers Services Organization (RCP-SO) was formed by RCPA as a stand-alone managed care solution. RCP-SO has a separate business structure, by-laws, and board of directors.

RCP-SO is based on the successful model of the Community Behavioral HealthCare Network of Pennsylvania (CBHNP), a provider-based solution for behavioral health managed care.

RCP-SO has Single Signer Authority (SSA) and will accept risk and a capitated payment to:

- manage the ABI long-term services and supports for individuals with ABI, and
- offer a conflict-free statewide network of service coordination entities (SCEs) and personal assistant services (PAS) providers under SSA.
## RCP-SO Products for Subcontract

<table>
<thead>
<tr>
<th>Products</th>
<th>Description</th>
<th>RCP-SO Advantage</th>
</tr>
</thead>
</table>
| ABI      | A stand-alone solution that will manage ABI long-term services and supports for individuals with ABI. | • MCO can focus efforts on 98% of population.  
• ABI population easily identifiable by finite set of diagnostic codes  
• Lifelong supports needs  
• ABI is not a nursing home population |
| SCEs     | Statewide network of SCEs currently serving the majority of individuals receiving long-term services and supports (LTSS) in PA. Data management design for high performance and streamlined reporting. | • Performance metrics/risk bearing  
• Single contract/standards  
• Statewide network  
• Efficient reporting  
• Established relationships with individuals receiving services  
• Face-to-face encounters |
| PAS      | Statewide network of PAS providers currently serving the many individuals receiving LTSS in PA. Data management design for high performance and streamlined reporting. | |

---

114
RCP-SO Service Model

Conflict Free Shared Function Care Management

Focused approach for PH/BH/LTSS Integration
- Additional targeted resources for high risk members
- Population-based approach serving as an extension of the MCO care team
- Responsive to the individual, not historical waiver usage

Performance and Risk-Based Contracting
- Clearly defined metrics to assess success
- Established model of care standards
- Targeted networks with provider collaboration

Expansive network covering all 67 counties

Comprehensive network from one contract with SSA
- Post Acute ABI
- SCEs
- PAS
Standardized LTSS data sets and reporting
Maximized consumer choice and access

Establish new performance metrics and goals

Proactive care management and data analytics support
Focus on number and quality of touch points
- In-home support and community-based interventions
RCP-SO’s managed care solution streamlines LTSS contracting and reporting through one organized entity.
Provider Credentialing Follow Up with Managed Care Organizations

January 14, 2016
Objectives of Presentation

- Discuss the outcomes from the comparison between the Office of Long-Term Living’s (OLTL) current provider credentialing process and Managed Care Organizations (MCO) provider credentialing processes
- Provide a high level overview of the provider credentialing process for Community HealthChoices (CHC)
- Receive feedback from MCOs
OLTL Provider Credentialing
Comparison with MCOs
OLTL conducted a series of webinars with nursing facilities, home and community based services providers, and managed care organizations.

One of the themes received is that provider credentialing for Long-Term Services and Supports providers should be consistent.

OLTL requested that MCO’s submit their credentialing information and process to us.
• Outcomes
  • Provider Reimbursement and Operations Management Information System (PROMISe™) Base Application
  • OLTL Provider Enrollment Information Form
  • Policies and Procedures
  • Other Documentation and Information
• In general OLTL currently collects more information than MCOs
• A few MCOs collect information that OLTL currently does not collect
Provider Credentialing for CHC
Considerations for CHC Provider Credentialing

- Credentialing and Contracting
- Discuss possibility of file exchanges
  - Requiring MCOs to use/report current data fields
    - PROMISe™ Provider Types and Specialties
- Provider Credentialing just for LTSS
- Physical Health Credentialing
- New Electronic Enrollment Application
  - Anticipated go-live late January 2016
Open Discussion MLTSS Provider Credentialing

• Are there questions or concerns
• Next Steps
• Email credentialing questions or concerns to: RA-PWMLTSS@pa.gov
  • Please include Provider Credentialing in the subject line
• CHC ListServ and other OLTL ListServs
  • http://listserv.dpw.state.pa.us
Office of Long-Term Living

January 14, 2016 Training Overview
MCO Meet and Greet
Elaine Smith, Bureau of Policy
And Regulatory Management
OLTL Trainings

- Sampling of OLTL Trainings
  - Face-to-face intensive training for Service Coordinators
  - New Provider orientations
  - Ongoing refreshers for direct service providers
  - Webinars
    - Protective Services
    - Risk Mitigation
    - Critical Incident Monitoring (upcoming)
    - Participant-Directed Services (upcoming)
    - Participant Monitoring Tool (upcoming)
    - OLTL Policy Bulletin-specific as issued
  - Budget Constraints in past 4 years have impacted training possibilities
OLTL Trainings

• Possible Future Training Topics related to CHC-MCOs
  – Service Definitions and Program Requirements
  – Independent Living Philosophy
  – Participant-Directed Service Model
  – Overview of Roles and Responsibilities of OLTL Partners – County Assistance Offices (CAOs), Area Agencies on Aging (AAAs), Centers for Independent Living (CILs), Independent Enrollment Broker (IEB), Public Partnerships, LLC (PPL)
  – Issues related to Service Coordination – 3rd party resources, Person-Centered Planning
  – Critical Incident Reporting
  – The LIFE Program
We need your input!

Greg Neff, OLTL Training Coordinator
c-gneff@pa.gov
Phone Number: 717-346-9172