Supporting a Healthy Home

Opportunities and Barriers to Medicaid for Permanent Supportive Housing Providers

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Medicaid and PSH

- Medicaid is a federal health program but **states have considerable flexibility in defining benefits**
- The Affordable Care Act **expanded Medicaid eligibility** to low-income adults without disabilities
- Most Medicaid beneficiaries in Illinois are required to enroll in a **Managed Care Organization (MCO)**
- Federal government is encouraging states to **fund PSH services through Medicaid**
Goals of report

- Document **barriers to accessing Medicaid** for PSH providers

- Describe **organizational capacities** necessary to become a Medicaid biller

- Provide **lessons learned** from PSH providers that have gone through the process of becoming certified to bill Medicaid
Methods

- Surveyed 101 supportive housing providers, with 39% response rate
- Interview 14 key stakeholders
- Scan of policy landscape
Findings
There is significant interest in Medicaid among PSH providers

- Only half of survey respondents bill Medicaid to support their services.
- Of those who do not bill Medicaid, two-thirds believe they will become a provider or partner with one in the future.

Interest in Medicaid Of Non-Medicaid-billing PSH Providers

- Yes, we will likely enroll as a Medicaid provider: 47%
- Yes, we will likely partner with a Medicaid provider: 20%
- No: 0%
- Unsure: 53%
PSH providers are more likely to be downstate than in Chicago

Geographic distribution of PSH providers, by Medicaid biller status
Many PSH providers lack organizational capacities needed to administer Medicaid

Number of units by Medicaid biller status

- 0 to 38 units: 26% non-Medicaid, 44% Medicaid
- 39 to 130 units: 32% non-Medicaid, 28% Medicaid
- 131 to 550 units: 42% non-Medicaid, 28% Medicaid

Budget size by Medicaid biller status

- $0 to $3,000,000: 26% non-Medicaid, 50% Medicaid
- $3,000,001 to $5,200,000: 26% non-Medicaid, 38% Medicaid
- $5,200,001 to $70,000,000: 47% non-Medicaid, 13% Medicaid

Staff size by Medicaid biller status

- 0 to 31 staff: 16% non-Medicaid, 56% Medicaid
- 33 to 105 staff: 37% non-Medicaid, 33% Medicaid
- 120 to 1200 staff: 47% non-Medicaid, 11% Medicaid
Many PSH providers lack organizational capacities needed to administer Medicaid

- Administrative, quality assurance procedures will likely need to change for many PSH providers

Organizational Changes Made by PSH Providers to Enroll in Medicaid

<table>
<thead>
<tr>
<th>Change</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Instituted new management/administrative procedures</td>
<td>65%</td>
</tr>
<tr>
<td>Instituted new billing system</td>
<td>50%</td>
</tr>
<tr>
<td>Purchased new IT system/software</td>
<td>35%</td>
</tr>
<tr>
<td>Offered new services</td>
<td>25%</td>
</tr>
<tr>
<td>Do not know</td>
<td>20%</td>
</tr>
<tr>
<td>Purchased new equipment</td>
<td>10%</td>
</tr>
<tr>
<td>Purchased new insurance</td>
<td>10%</td>
</tr>
<tr>
<td>Built new facilities</td>
<td>0%</td>
</tr>
<tr>
<td>Did not make organizational changes as a condition of enrolling as a Medicaid provider</td>
<td>0%</td>
</tr>
</tbody>
</table>
Many PSH providers lack organizational capacities needed to administer Medicaid

- Non-Medicaid-billing PSH providers are less likely to have clinical staff
- Administrative staff are a large need for billing Medicaid

Presence of clinical staff, by Medicaid biller status

- Medicaid-billing PSH provider: 100% has clinical staff
- Non-Medicaid-billing PSH provider: 59% has clinical staff, 41% does not have clinical staff
Many PSH providers lack organizational capacities needed to administer Medicaid

- **Technology** can be a financial, staff training hurdle
  - Electronic client/medical records
  - Electronic billing system

<table>
<thead>
<tr>
<th></th>
<th>Medicaid-billing PSH provider</th>
<th>Non-Medicaid-billing PSH provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>My organization does not have internet access</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Not all staff members within my organization have email capability</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>My organization does not currently use an electronic billing system</td>
<td>7%</td>
<td>61%</td>
</tr>
<tr>
<td>My organization does not currently have the capacity to measure the success of services we provide</td>
<td>0%</td>
<td>6%</td>
</tr>
<tr>
<td>My organization does not document services in an electronic resident/client record</td>
<td>21%</td>
<td>17%</td>
</tr>
<tr>
<td>None of the above</td>
<td>64%</td>
<td>17%</td>
</tr>
<tr>
<td>Other</td>
<td>14%</td>
<td>22%</td>
</tr>
</tbody>
</table>
Many PSH providers lack organizational capacities needed to administer Medicaid

“There was lots of debate about whether or not we should [become Medicaid certified]. The big issue was infrastructure. It wasn’t that the services that we provided were not compliant, because we knew they were—it was more that developing the billing infrastructure was going to be challenging. At the time, we were doing hard copy files—making that shift to electronic billing is a huge challenge.”

– Michael Banghart, Renaissance Social Services, Inc.
The process of enrolling as a Medicaid provider in Illinois is confusing and difficult for many PSH providers

- How do services offered fit in with Medicaid rules?
- Do they meet organizational requirements?
- Follow steps to become licensed/certified through DASA or DMH – can be duplicative
- Only a third of Medicaid-billing PSH providers received training/TA on the process
- Incurred administrative, personnel costs to become Medicaid billers
Medicaid’s structure in IL poses barriers for Medicaid-billing PSH providers

- Two certifications needed to provide full suite of mental health and substance use services
- Contracting with MCOs
Medicaid’s structure in IL poses barriers for Medicaid-billing PSH providers

- Burdensome billing and documentation requirements
- Limitations in billable services and reimbursement rates

### Administrative Impact Of Medicaid On Medicaid-billing PSH Providers

- Negative impact: 18%
- Somewhat negative impact: 35%
- No impact: 6%
- Somewhat positive impact: 18%
- Positive impact: 24%
Medicaid can change scope of services delivered, population served

Selected Services Offered at PSH Providers,
by Medicaid Biller Status

- Mental health services: 89% Medicaid, 35% Non-Medicaid
- Substance use services: 61% Medicaid, 47% Non-Medicaid
- Medication monitoring: 78% Medicaid, 24% Non-Medicaid
- Primary care: 50% Medicaid, 33% Non-Medicaid
- Financial literacy: 77% Medicaid, 12% Non-Medicaid
- Legal services: 77% Medicaid, 11% Non-Medicaid
- Child care: 29% Medicaid, 29% Non-Medicaid
- Clothing: 39% Medicaid, 14% Non-Medicaid
Medicaid can change scope of services delivered, population served

Selected Populations Served by Medicaid Biller Status
Managed Care relationships can be challenging

- 89% of Medicaid-billing PSH providers contract with MCOs

**Administrative Impact Of MCO Contracting On Medicaid-billing PSH Providers**

- Negative impact: 20%
- Somewhat negative impact: 33%
- No impact: 7%
- Somewhat positive impact: 33%
- Positive impact: 7%

**Return On Investment Of MCO Contracting For Medicaid-billing PSH Providers**

- Very good return on investment: 13%
- Somewhat good return on investment: 40%
- Not sure: 13%
- Somewhat poor return on investment: 27%
- Very poor return on investment: 7%
Managed Care relationships can be challenging

Are MCOs’ Billing and Reimbursement Systems an Improvement Over Medicaid Fee-for-service Systems?

- Yes — 27%
- Comparable — 13%
- Unsure — 13%
- No — 47%

Impact Of MCO Contracts On Service Delivery

- Greater flexibility — 13%
- Less flexibility — 47%
- No impact — 40%
Despite challenges, Medicaid-billing PSH providers recommend Medicaid to others

Perceptions Of Medicaid Return On Investment, Medicaid-billing PSH Providers

- Very good return on investment: 28%
- Somewhat good return on investment: 22%
- Not sure: 11%
- Somewhat poor return on investment: 22%
- Very poor return on investment: 17%

Would you recommend that other PSH providers enroll as Medicaid providers?

- Yes: 62%
- Unsure: 38%
Medicaid-billing PSH providers weathered the budget crisis better than non-billers

Selected responses to the Illinois budget crisis, by Medicaid biller status

- Reduce staff: 63% Medicaid-billing, 94% Non-Medicaid-billing
- Reduce caseload: 21% Medicaid-billing, 50% Non-Medicaid-billing
- Skip payroll: 5% Medicaid-billing, 11% Non-Medicaid-billing
- Tap into cash reserves: 63% Medicaid-billing, 72% Non-Medicaid-billing
- Tap into lines of credit: 26% Medicaid-billing, 33% Non-Medicaid-billing
Emerging partnership models
Health Neighborhoods

HHO

Deborah’s Place

Northside Housing

Heartland Human Care Services

Chicago House

Leased staff

Leased staff

Leased staff
Implications for PSH providers

- Consider becoming a certified Medicaid provider
- Explore partnerships with traditional health and behavioral health organizations
- Invest in data systems
Implications for policymakers and MCOs

Reduce the challenges associated with becoming a certified Medicaid provider

- Develop ways to share data across agencies and develop a centralized certification system that authorizes providers of most Medicaid services
- Simplify and standardize provider criteria across Rule 132, Rule 2060, and Rule 2090
- Provide more technical support to community Medicaid providers
Implications for policymakers and MCOs

- Simplify billing and documentation requirements
  - Provide greater clarity regarding Medicaid beneficiary eligibility for services and the process to authorize them
  - Standardize billing for services across various MCOs and the state
  - Review and reduce duplicative documentation requirements across eligible service categories
Implications for policymakers and MCOs

Pursue Medicaid supportive housing benefit

• Provide expansive set of pre-tenancy, tenancy, and planning/evaluation services
• Establish clear eligibility requirements for beneficiaries
• Structure reimbursement around a case rate
• Use quality metrics to promote provider accountability rather than extensive documentation requirements
• Facilitate innovative contracting arrangements with MCOs
• Evaluate savings generated from the new benefit and devote some of these savings to new affordable housing resources
Implications for policymakers and MCOs

- Adequately fund existing PSH funding streams
  - Review and increase rates for services
  - Maintain supportive housing grants funded by the state budget