
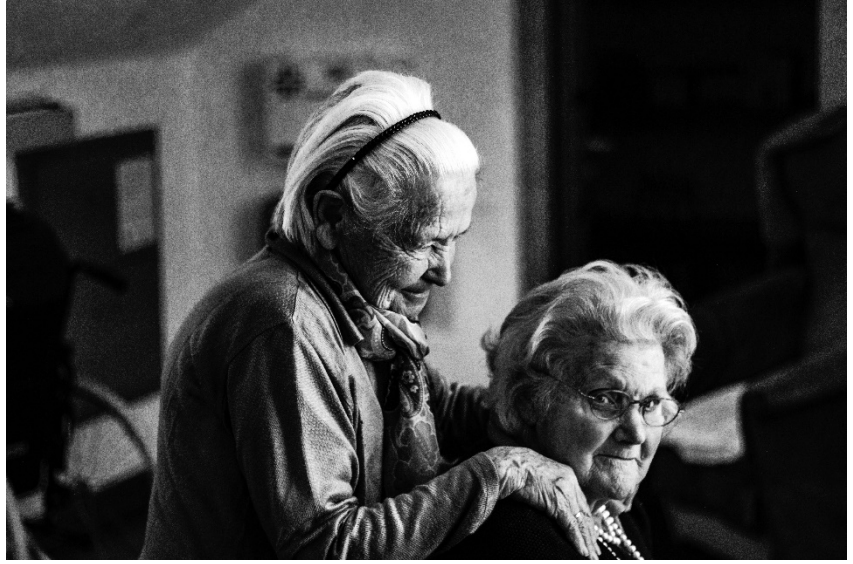


Foundational Community Supports

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(360) 725-9997

November, 2019

Healthier WASHINGTON

HEALTH IS WHERE WE LIVE, LEARN, WORK & PLAY

Stable Jobs = Healthier Lives

American adults spend nearly half their waking hours at work. Whether we work—and under what conditions—influences our health. Employment provides the income, benefits and stability necessary for a healthy life[1].

Unemployment may affect health in many ways. Laid-off workers are[5]:

54% more likely to have fair or poor health.

https://www.rwjf.org/en/library/infographics/infographic--stable-jobs---healthier-lives.html#/embed

Healthier WASHINGTON

83% more likely to develop a stress-related condition such as heart disease.

https://www.rwjf.org/en/library/infographics/infographic--stable-jobs---healthier-lives.html#/embed

Healthier WASHINGTON

Unemployment has also been linked to[6]:

Loss of Health Insurance

Increased Stress & Blood Pressure

Unhealthy Coping Behaviors

Increased Depression

https://www.rwjf.org/en/library/infographics/infographic--stable-jobs---healthier-lives.html#/embed

Healthier WASHINGTON

Waiver Initiatives

Initiative 1

Transformation through Accountable Communities of Health

Delivery System Transformation

- Each region, through its Accountable Community of Health, will be able to pursue projects that will transform the Medicaid delivery system to serve the whole person and use resources more wisely.
- Also known as Delivery System Reform Incentive Payments (DSRIP).

Pay for Performance Projects

Initiative 2

Enable Older Adults to Stay at Home; Delay or Avoid the Need for More Intensive Care

Benefit: Medicaid Alternative Care (MAC)

- Community-based option for Medicaid clients and their families.
- Services to support unpaid family caregivers.

Benefit: Tailored Supports for Older Adults (TSOA)

- For individuals "at risk" of future Medicaid LTSS not currently meeting Medicaid financial eligibility criteria.
- Primarily services to support unpaid family caregivers.

Initiative 3

Targeted Foundational Community Supports

Benefit: Supportive Housing

- Individualized, critical services and supports that will assist Medicaid clients to obtain and maintain housing. The housing-related services do ***not*** include Medicaid payment for room and board.

Benefit: Supportive Employment

- Services such as individualized job coaching and training, employer relations, and assistance with job placement.

Medicaid Benefits/Services

Healthier WASHINGTON

How did we get here?

2015

MTP Application
HCA submits an application to CMS to implement the 5-year Medicaid Transformation Project

2017

TPA Contract
HCA awards Amerigroup contract to administer FCS benefits

MTP Approval
CMS establishes special terms and conditions (STCs) for how HCA will implement, evaluate and finance MTP

2018

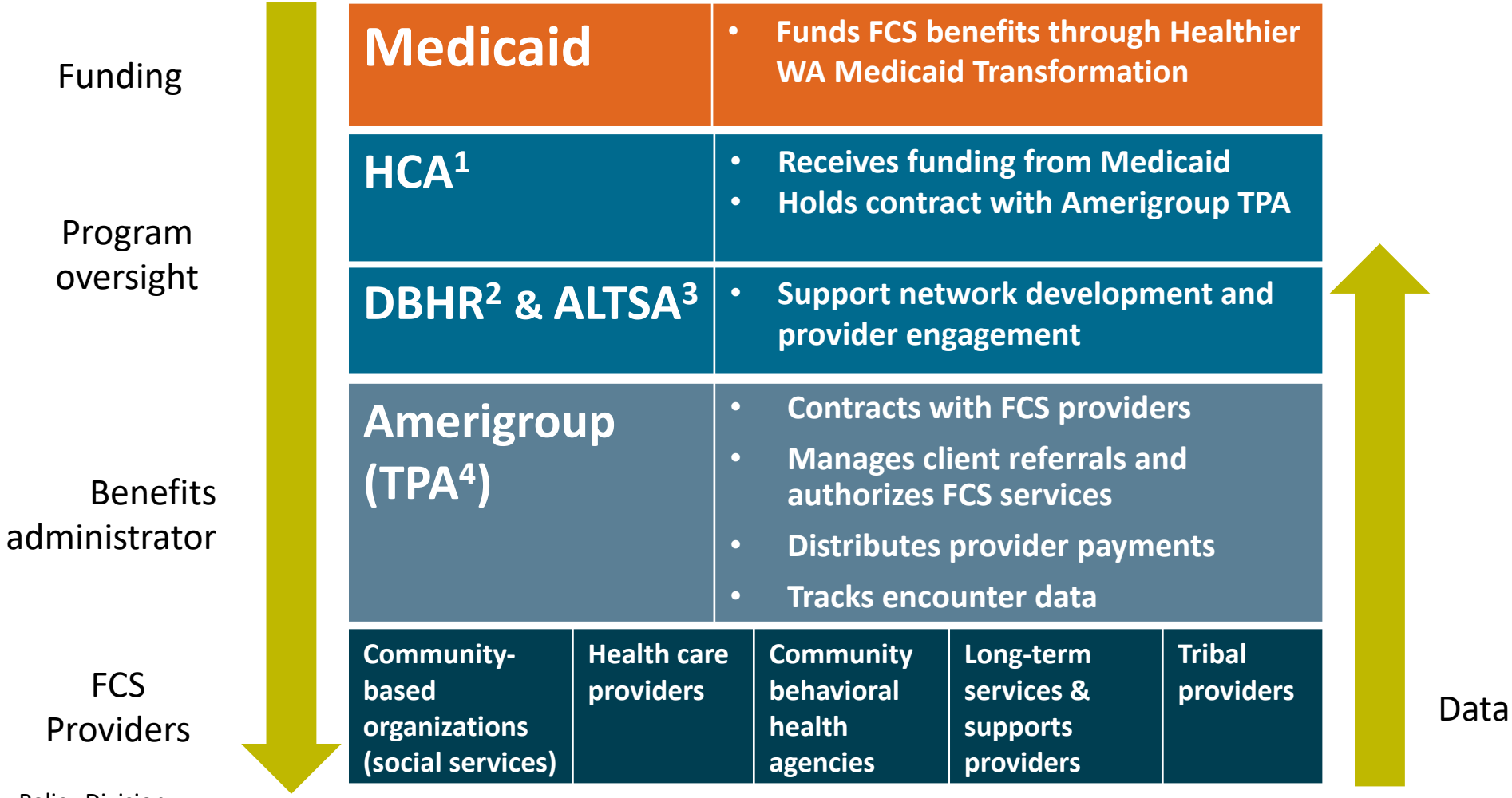
FCS Protocol
CMS approves HCA's protocol for FCS benefits, client eligibility and provider payment

FCS Launch
Eligible Medicaid clients can receive supported employment and supportive housing benefits

*CMS - Centers for Medicare & Medicaid Services, the federal agency that works in partnership with state governments to administer Medicaid

Healthier WASHINGTON

How is Foundational Community Supports structured?



1. Health Care Authority – Policy Division
2. Health Care Authority - Division of Behavioral Health & Recovery
3. Department of Social & Health Services - Aging and Long-term Support Administration
4. Third Party Administrator

Healthier WASHINGTON

What is Foundational Community Supports?

It is…

- Medicaid benefits for help finding **housing** and **jobs**:
  - Supportive Housing to find a home or stay in your home
  - Supported Employment to find the right job, right now

It isn't…

- Subsidy for wages or room & board
- For all Medicaid-eligible people

Healthier WASHINGTON

What benefits are available through Foundational Community Supports?

Supportive housing helps you find a home or stay in your home

- ✓ Housing assessments and planning to find the home that's right for you
- ✓ Outreach to landlords to identify available housing in your community
- ✓ Connection with community resources to get you all of the help you need, when you need it
- ✓ Assistance with housing applications so you are accepted the first time
- ✓ Education, training and coaching to resolve disputes, advocate for your needs and keep you in your home

Healthier WASHINGTON

What benefits are available through Foundational Community Supports?

Supported employment helps you find the right work, right now

- ✓ Employment assessments and planning to find the right job for you, whenever you're ready
- ✓ Outreach to employers to help build your network
- ✓ Connection with community resources to get you all of the help you need, when you need it
- ✓ Assistance with job applications so you can present your best self to employers
- ✓ Education, training and coaching to keep you in your job

Healthier WASHINGTON

Who is eligible to receive Foundational Community Supports benefits?

FCS benefits are reserved for people with the greatest need. To qualify, you must:

1. **Be enrolled in Medicaid**

2. **Be at least 18 years old (Supportive Housing) or 16 years old (Supported Employment)**

3. **Meet the requirements for complex needs**
   - You have a **medical necessity** related to mental health, substance use disorder (SUD), activities of daily living, or complex physical health need(s) that prevents you from functioning successfully or living independently.
   - You meet specific **risk factors** that prevent you from finding or keeping a job or a safe home.

Healthier WASHINGTON

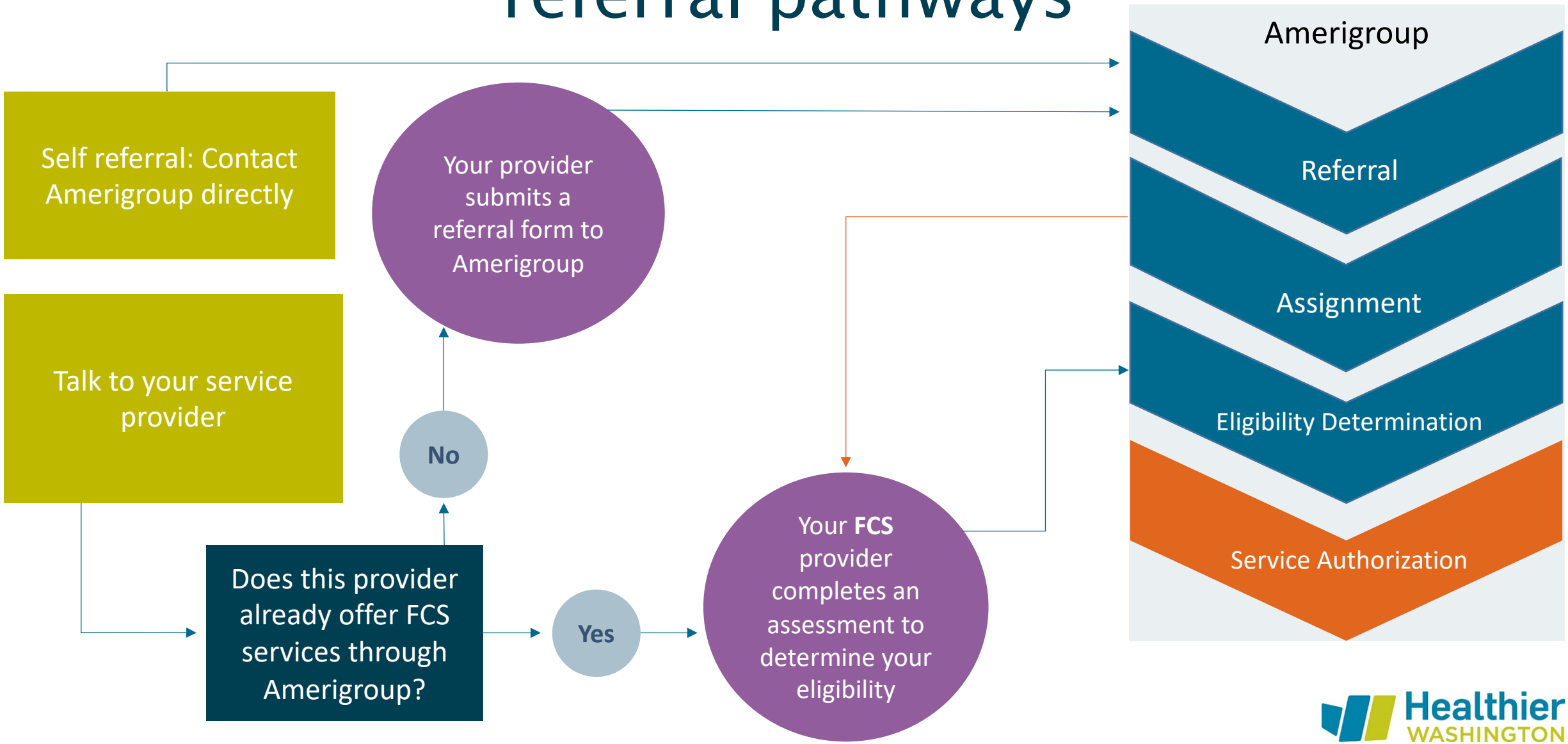
Who is eligible to receive Foundational Community Supports benefits?

Supportive Housing risk factors *One or more*	Supported Employment risk factors *One or more*
✓ Chronic homelessness	✓ Housing & Essential Needs (HEN) and Aged Blind or Disabled (ABD) enrollees
✓ Frequent or lengthy stays in an institutional setting (e.g. skilled nursing, inpatient hospital, psychiatric institution, prison or jail)	✓ Difficulty obtaining or maintaining employment due to age, physical or mental impairment, or traumatic brain injury
✓ Frequent stays in residential care settings	✓ SUD with a history of multiple treatments
✓ Frequent turnover of in-home caregivers	✓ Serious Mental Illness (SMI) or co-occurring mental and substance use disorders
✓ Predictive Risk Intelligence System (PRISM)[1] score of 1.5 or above	

1. PRISM measures how much you use medical, social service, behavioral health and long-term care services.

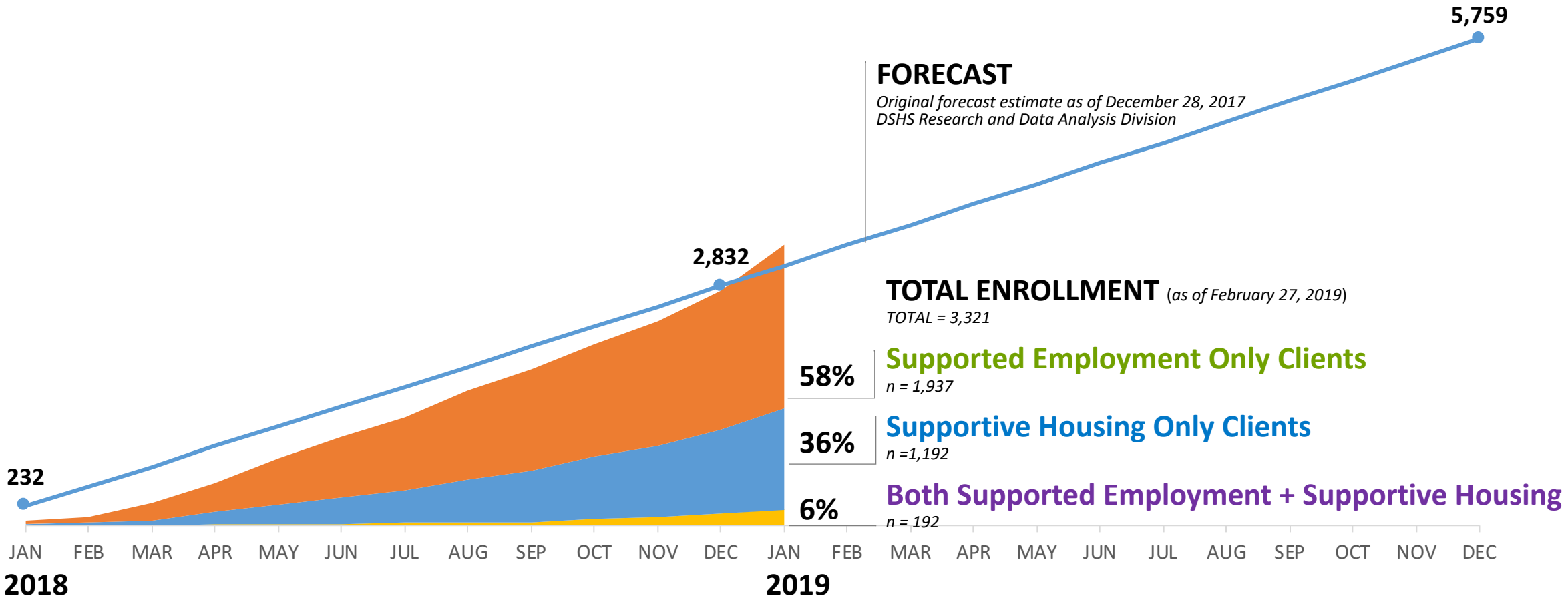
Healthier WASHINGTON

Foundational Community Supports referral pathways



Healthier WASHINGTON

Foundational Community Supports enrollment



SOURCE: DSHS Research and Data Analysis Division, Integrated Databases
DATE: March 2019

Amerigroup Washington

Foundational Community Supports Third Party Administrator

Amerigroup as the FCS TPA

We're contracted with the HCA as the Third Party Administrator (TPA) of FCS and provide administrative oversight of:

- Provider Network
- Service Authorization
- Claims payment and encounter tracking/reporting
- Measuring outcomes and quality improvement
- Sustainability Plan

Enrollee Count

We currently have more than 5,500 people enrolled in the Foundational Community Supports (FCS) program

Region	SE	SH	SE + SH	Total
Great Rivers	383	382	197	962
Greater Columbia	254	271	76	601
King	304	378	20	702
North Central	122	73	11	206
North Sound	353	205	34	592
Pierce	203	277	51	531
Salish	49	46	24	119
Southwest	132	85	9	226
Spokane	547	681	220	1448
Thurston-Mason	140	56	10	206
Grand Total	2,487	2,454	652	5,593

Provider Network

A FCS Provider Network continues to expand across WA state. We have 128 contracted providers.

Region	SE	SH	SE + SH	Total
Great Rivers	5	1	27	33
Greater Columbia	7	3	26	36
King	18	10	63	91
North Central			16	16
North Sound	14	3	24	41
Pierce	10	5	17	32
Salish	5		19	24
Southwest	2	1	9	12
Spokane	4	7	49	60
Thurston-Mason	4	1	13	18
Grand Total	69	31	263	363

Referrals

Anyone can refer a potential enrollee to the FCS program

- Potential Enrollee
- Family member
- Provider
- Aging and Long-term Support Administration (ALTSA)
- Division of Behavioral Health & Recover (DBHR)

Quick Reference Guide is a tool to quickly evaluate if a potential enrollee may be eligible for Supportive Housing and/or Supported Employment services.

FCS service reimbursement

There are only three HCPCS billing codes for the FCS program.

- **Supported Employment**
  Pre-employment services HCPCS code: H2023
  Employment sustaining services HCPCS code: H2025
  - Limit of 120 units (30 hours; 1 unit = 15 minutes) of service per 6 month authorization period
  - Reimbursement rate of $25/unit of service

- **Supportive Housing**
  Pre-housing and sustaining services: H0043
  - Limit of 30 days of service per 6 month authorization period
  - Reimbursement rate of $105/day

- Services may be reauthorized if a FCS enrollee continues to need services

Expanding Provider Network

Providers interested in joining the provider network must have:

- Tax ID
- Medicaid ID
- National Provider Identifier (NPI)

To learn more about becoming a contracted FCS provider, contact us at FCSTPA@Amerigroup.com or 844-451-2828.

Advisory Council

An FCS Advisory Council has been established as a mechanism to incorporate client voice into services, processes, and outcomes

- Enrollees
- Providers
- Stakeholders
- Advocates across Washington

Email FCSTPA@Amerigroup.com if you're interested in joining the Advisory Council.

Where are we going?

Access

2018: Establish a comprehensive provider network to serve clients statewide

Quality

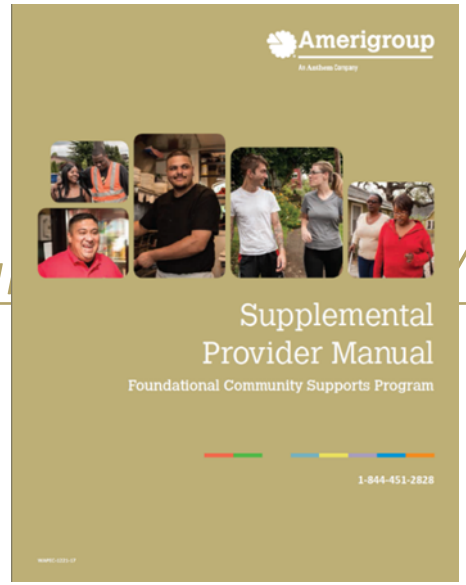
2019: Institute continuous quality improvement standards

Sustainability

2021: Evaluate effectiveness, with the goal of continuing FCS as a permanent Medicaid benefit

FCS Websites + Provider Manual

FCS Resources available at your finger tips



- Amerigroup FCS Provider Website: *https://providers.amerig[illegible]/wa-foundational-community-supports.aspx*
  - Provider Manual
  - Referral + Assessment Forms
  - Quick Reference Guide
- FCS Provider Resource Guide: https://www.hca.wa.gov/assets/program/FCS-provider-resource-guide.pdf
- Amerigroup FCS Client Website: *https://www.myamerigroup.com/washington-fcs/home.html*

We’re here for you

Amerigroup Washington, Inc.
Third Party Administrator

FCSTPA@Amerigroup.com
Phone: 844.451.2828
Fax: 844.470.8859

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Leeza Lorence
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1115 Waiver and the Grays Harbor County Homeless Response System

GRAYS HARBOR
Public Health &
Social Services

The stars align…

System challenges

- Homeless housing resources limited to serving 1 in 4 of literally homeless clients who present at Coordinated Entry
- Those clients who do qualify and were prioritized for resources often disengaged before those resources became available
- State and County homeless housing funds are precious resources because they can pay for rental assistance – how can we maximize/leverage these limited resources to serve more people and serve them better?
- Challenge for care coordinators to provide meaningful structure/support for clients who were enrolled – no road map for services

Summer of 2018

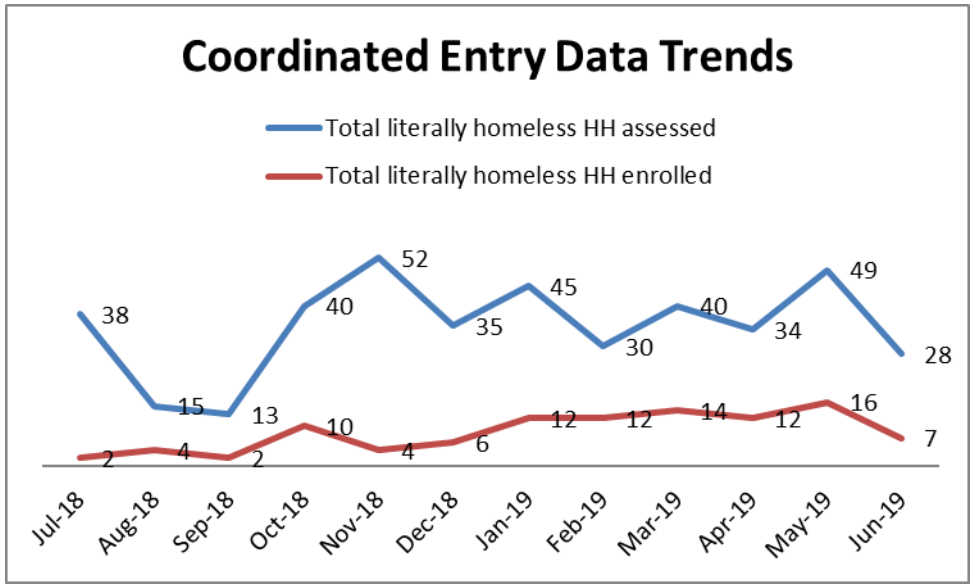
- 2017 Onsite Monitoring identified system questions
- Implementation of FCS programs
- Coordinated Entry re-design
- CCAP fire
- USDA Capacity Building grant brought cross-system leadership to the planning table

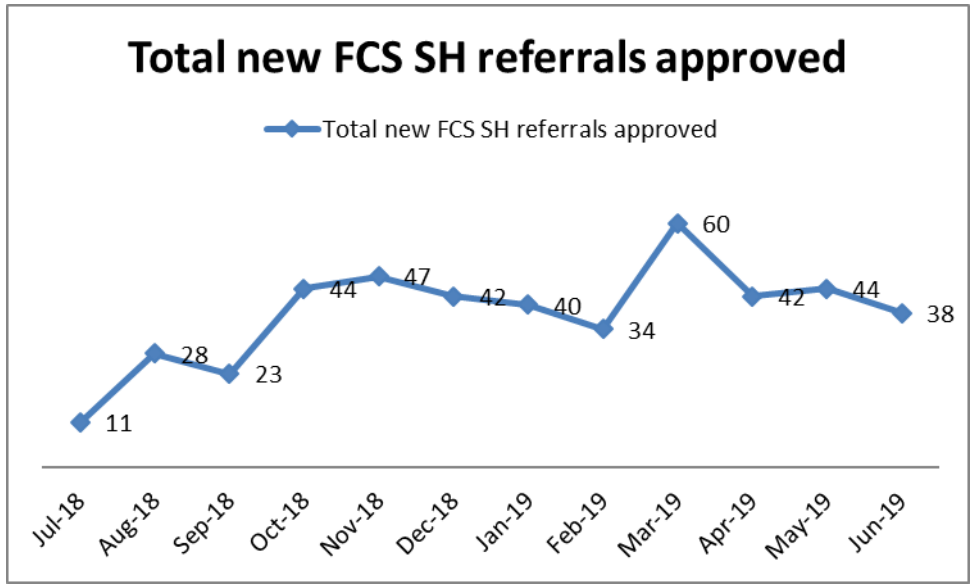
Coordinated Entry Data Trends 2018-19

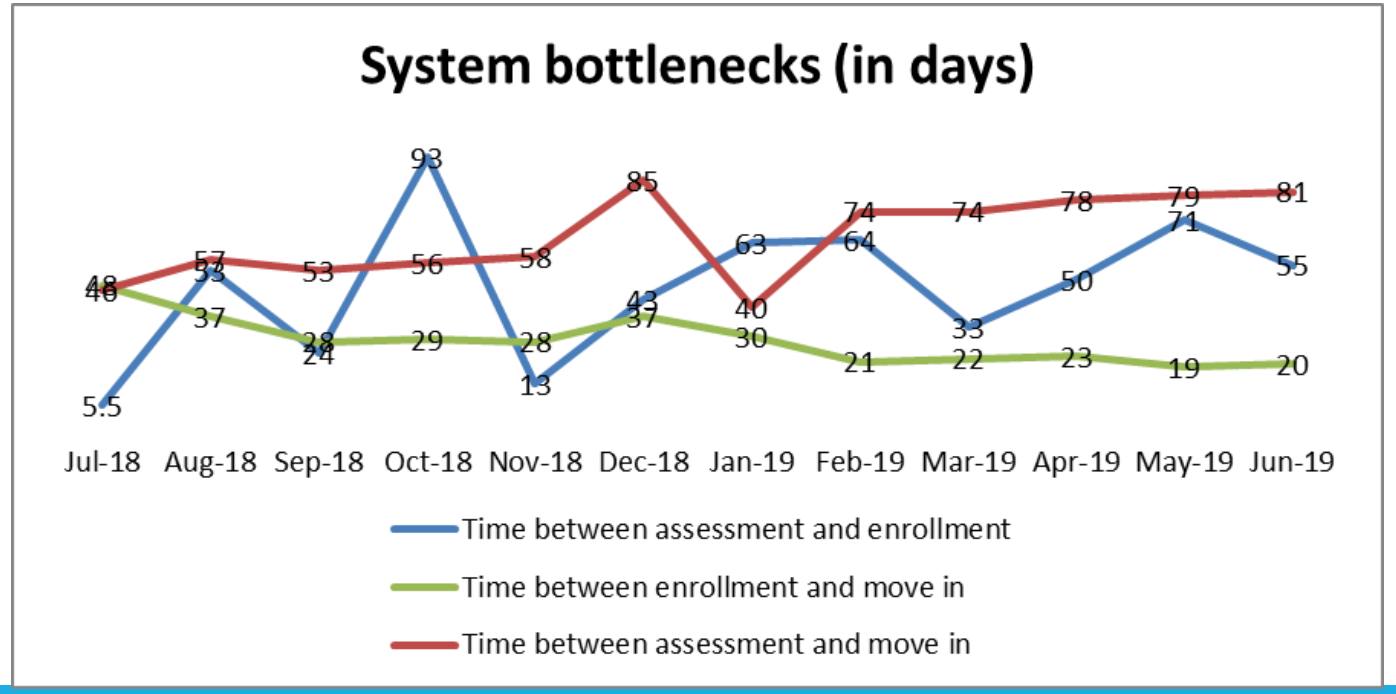
Data	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Total (12 months)	Average
Assessments														
Total literally homeless HH assessed	38	15	13	40	52	35	45	30	40	34	49	28	419	35
Total literally homeless families assessed	11	1	7	15	19	5	11	8	7	7	12	3	106	9
Total literally homeless single adults	27	14	6	25	33	30	34	21	33	27	37	25	312	26
Total literally homeless Veterans assessed	1	1	0	1	2	1	1	1	5	2	3	1	19	2
Average priority score assessed*	7	10.5	12.8	11.8	13.2	14	13.6	15	14	13.5	14	13.5		13
Total households at risk	16	4	11	13	23	17	19	15	18	14	52	46	248	21
Total youth/YA HH assessed	9	1	6	7	9	8	10	3	5	6	9	8	81	7
Total at-risk Veterans assessed	2	0	1	1	1	0	0	0	1	0	0	1	7	1
Total households who have been through CE before					19	12	17	14	14	15	5	9	105	9
Total % who have been through CE before					25%	23%	26%	33%	24%	31%	5%	12%		36%
Total households assessed overall	54	19	24	53	75	52	64	45	58	48	101	74	667	56
Enrolled														
Total literally homeless HH enrolled	2	4	2	10	4	6	12	12	14	12	16	7	101	8
Total literally homeless families enrolled	2	1	1	2	3	2	7	1	3	2	4	4	32	3
Total literally homeless single adults enrolled	0	3	1	8	1	4	5	11	11	10	12	3	69	6
Total literally homeless Veterans enrolled	0	2	0	1	0	0	2	0	0	1	1	0	7	1
Average priority score enrolled*	7.5	10.5	16	13.5	18.8	16.5	15.7	16.4	17.5	13	15	16		15
Total households at risk enrolled	0	0	0	0	1	0	7	1	5	14	11	6	45	4
Total youth/YA HH enrolled	0	1	1	0	1	0	2	1	2	2	3	3	16	1
Total at-risk Veterans enrolled	0	0	0	0	0	0	0	1	0	1	0	0	2	0
Total new FCS SH referrals approved	11	28	23	44	47	42	40	34	60	42	44	38	453	38
Total households "diverted"											0	1	1	1
Average time between assessment and enrollment (days)	5.5	53	24	93	13	43	63	64	33	50	71	55		47
Average time between enrollment and move-in (days)	48	37	28	29	28	37	30	21	22	23	19	20		29
Average time between assessment and move-in (days)	46	57	53	56	58	85	40	74	74	78	79	81		65
Total households enrolled	2	4	2	10	5	6	19	13	19	26	27	13	146	12
Total households housed	0	1	1	0	15	11	9	8	10	12	7	11	85	7

Difference/Gap (Total assessed - Total enrolled)	52	15	22	43	70	46	45	32	39	22	74	60	520	43
Unsheltered difference/gap (total assessed - total enrolled)	36	11	11	30	48	29	33	18	26	22	33	20	317	26

*Note changed from VISPDAT to custom tool Aug 1 2018


Coordinated Entry Data Trends
Total literally homeless HH assessed
Total literally homeless HH enrolled
38
15
13
40
52
35
45
30
40
34
49
28
2
4
2
10
4
6
12
12
14
12
16
7
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19


Total new FCS SH referrals approved
Total new FCS SH referrals approved
11
28
23
44
47
42
40
34
60
42
44
38
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19


System bottlenecks (in days)
5.5
93
13
63
64
33
50
71
55
48
57
53
56
58
85
40
74
74
78
79
81
37
28
29
28
37
30
21
22
23
19
20
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Time between assessment and enrollment
Time between enrollment and move in
Time between assessment and move in

Assessment Date: Click here to enter text. **HMIS ID#:** Click here to enter text._____

Section 1: Eligibility Characteristics

Do you any of the following apply to you? (Check all that apply)

☐ Served in the military/Veteran★

☐ Are currently or was recently in treatment for mental health/chemical dependency (inpatient or outpatient)

☐ Currently enrolled in TANF (or was enrolled in TANF without using 60 months)

☐ Currently enrolled in HEN or ABD

Integration Key:

▲ Client answered on CCAP Client Intake

❯ Client answered on Coordinated Entry Housing Eligibility Screening

★ Client answered in HMIS profile

● FCS Supportive Housing Assessment Question

✚ Pathways Question

Section 2: Assessment and Prioritization

Category	Assessment Questions
Safety (Maximum score: 3) **Score:** Click here to enter text.	**1. Have you ever been a victim of domestic violence?** Yes ☐ No☐ Refused ☐ *If yes, add score of 1.* ❯ **2. Are you *currently fleeing* domestic violence?** Yes ☐ No ☐ Refused ☐ *If yes, add score of 2.* ❯ ✚ ***If household is currently fleeing domestic violence, verify they have contacted DVC or call DVC hotline before proceeding. If not offer resources and give client choice to make warm handoff to DVC.*** Additional Notes: Click here to enter text.
Unsheltered (Maximum score: 3) **Score:** Click here to enter text.	**3. Is household currently unsheltered (in car, outside, etc)?** Yes ☐ No ☐ Refused ☐ *If yes, add score of 3.* ❯ ● ✚ *If head of household is unsheltered, the household is considered unsheltered.* *If client answers yes skip question 4* **4. Is household temporarily sheltered (i.e. emergency shelter, hotel paid by charitable organization, or institutional setting for at least 90 days) AND was either unsheltered in the last 30 days, or will be unsheltered within 72 hours?** Yes☐ No ☐ Refused ☐ *If yes, add score of 1* ❯ ✚ Additional Notes: Click here to enter text.
Chronicity of Homelessness (Maximum score: 3) **Score:**	**5. For how long have you been continuously homeless?** ● **6. How many times have you been housed, then become homeless again in the past 3 years?** _____ **Added together, about how many months were you homeless total?** _____ months ● *If continually homeless 1 year or longer, **OR** 4 or more instances of homelessness in the last three years **that equal***

GHCE Process Flow

Step 1: Initial screening/intake

Step 2: Diversion conversation

Step 3: Assessment/ prioritization interview

Step 4: Matching and put on Google Docs

Step 5: Care coordination/ Diversion Part 2

Step 6: Enrollment in housing program

Data Entry Process Flow

Data 1: Put client intake information into CAP 60

Data 2: Create client profile and enter into CE program in HMIS

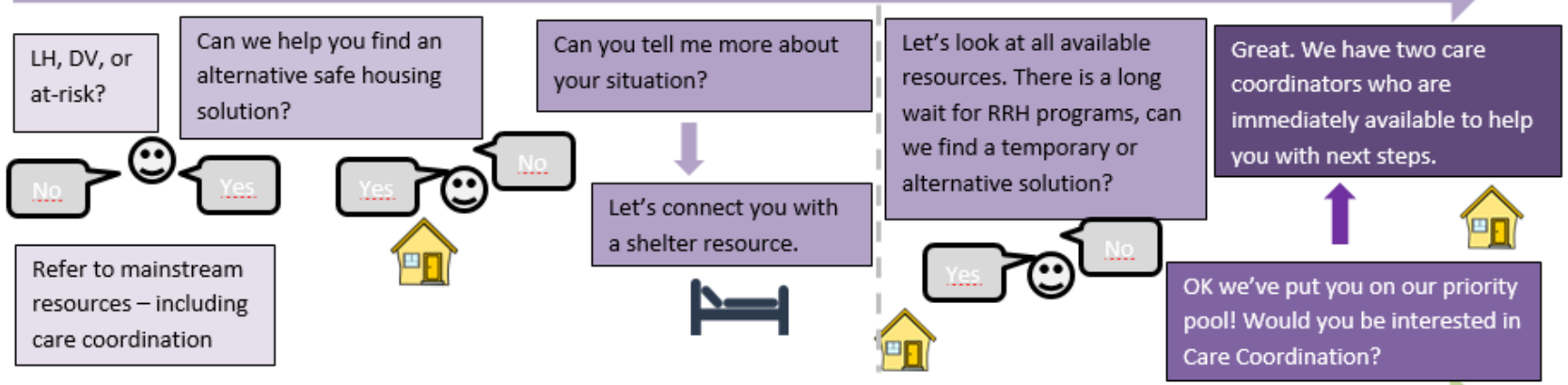
Data 3: Record result of Diversion in CE program (HMIS), fill out responses to assessment prioritization interview, record referrals. Exit client note outcome.

Data 4: GHCE staff records eligibility and vulnerability score on Google docs for all relevant programs

Data 5: Client meets with CE Care Coordinator.

Data 6: Resources permitting client is enrolled in housing

Client Experience Flow



Funding Process Flow

Step 1: No funding involved

Step 2: Diversion

- UWGH
- FEMA
- Lyle Smith
- Pooled Benevolence

Step 3: FCS

Step 4: Matching

- Salvation Army
- DSHS
- HARPS
- VRF

Step 5: Diversion Part 2

- UWGH
- FEMA
- Pathways
- FCS Services
- Pooled Benevolence

Step 6: Enrollment

- CHG
- CJTA
- FCS
- EFH
- HEN
- TBRA
- SSVF
- Fam RRH
- YA RRH
- TC
- McKinney PSH

The County Perspective

- Shift from system where CHG was the only game in town to working as a partner with other funders
  - The County is accountable for performance of the entire homeless response system – both County funded and non-County funded components
- As stewards of public funds the goal is to maximize all available resources
- If the system isn't simple -it's not sustainable
  - Data entry
  - Documentation
  - System flow/process
  - Client/care coordinator experience

Impact of Integration

- We now can offer care coordination to the other 3 in 4 clients who do not get rental assistance through Coordinated Entry
- We can now connect immediately at Coordinated Entry to care coordination to increase engagement
- Clients have a streamlined assessment experience – avoid asking the same question multiple times
- Pathways Care Coordination offers prescriptive framework for care coordination across all programs
- FCS offers sustainable funding stream for scaling up care coordination

There is still work to do

- Not enough funding for housing subsidies
- Not enough affordable housing
- Individual client and system success relies on collaboration and communication
  - Behavioral Health – outpatient and crisis
  - Medical Health
  - Education/Employment
  - Family support services

Contact Information

Cassie Lentz

Social Services Manager

Grays Harbor County Public Health and Social Services

360-500-4049

clentz@co.grays-harbor.wa.us

www.healthygh.org/directory/housing

GRAYS HARBOR
Public Health &
Social Services

FCS Supportive Housing in Action

Craig Dublanko & Jason Hoseney

Coastal CAP Overview

- Quick Agency Summary
  - Rural CCAP Agency in Western Washington
  - Serving Grays Harbor and Pacific Counties
  - $17 Million in 2018
  - Approx. 200 Employees
- One Stop Coordinated Entry
- Existing Housing & Supported Employment Program
  - Housing Case Management Standards
  - Employment Services

Coastal CAP Overview

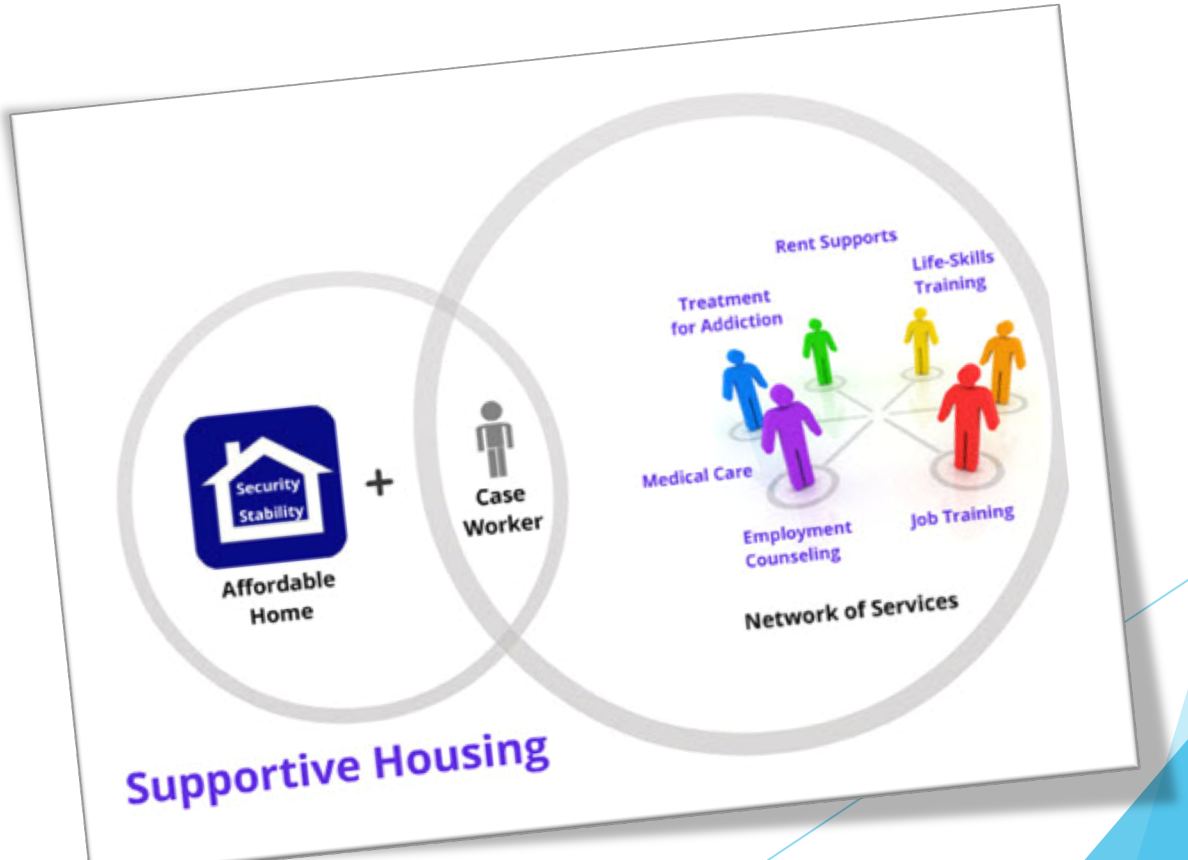
- Transformation Waiver
  - Coastal CAP focused on Initiative 3 from the beginning
  - Initiative 3 lined up with the programs we were already running
- FCS Integration
  - Coordinated Entry
  - Employment
- Increased Staff
  - Allowed us to improve our client/staff ratio
  - Allowed us to serve clients we otherwise would not have been serving
    - Both Employment & Housing

Coastal CAP Overview

- Pathways
  - Gave us a consistent approach to treating Homelessness
    - No more House and Hope…
  - Integrated into Coordinated Entry
  - Cross-training all housing staff in Pathways model of service delivery
  - Testing tablets to use the Pathways software in the field
  - Became another source of revenue for case management

Benefits

- Serve More Clients – Over 250 FCS Authorized Clients
- Lower Case Manager to Client Caseloads (Added 10 new full-time staff)
- More Holistic Approach (focus on wellness and health care) to Helping Clients Reach Self-Sufficiency

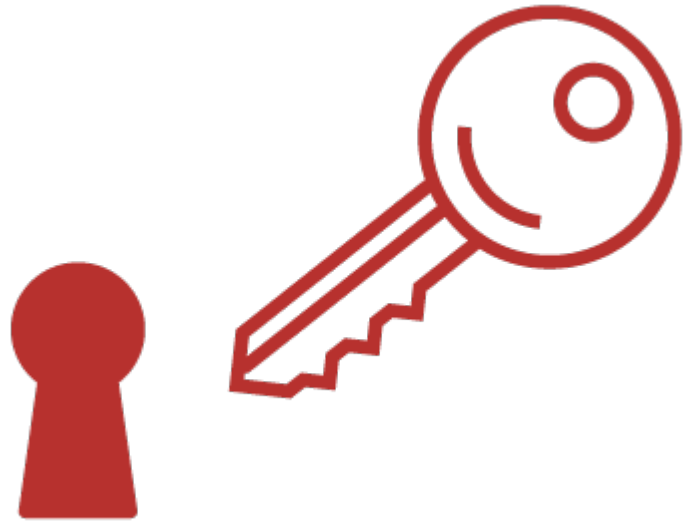


Step by Step

- Coordinated Entry
- Authorization / Assign to a Case Manager
- Individualized Assessment / Develop a Stability Plan
- Care Coordination / Make Connections
- Monitor Progress

Coordinated Entry

- Dual Purpose – Prioritize for Housing / Access to Care Coordination Services
- Internal vs. External Referrals
- Identify Eligible Clients (FCS Supportive Housing and/or Pathways)
- Integrate CE with Authorization (“would you like case management?”)



Pathways Eligibility Criteria

- 1. **Does the person have a behavioral health concern?**
  - Mental health
  - Substance use

- 2. **Is there an additional concern?**
  - **Pregnancy**
  - **Chronic disease**
  - **Co-occurring behavioral health**

- 3. **Are there additional risk factors?**
  - **Housing insecurity**
  - **Recent release from hospital**
  - **Frequent need to use 911**

FCS Supportive Housing Eligibility

- Health Need
  - Mental health need where there is a need for improvement, stabilization or prevention of deterioration to functioning resulting from the presence of a mental illness
  - Diagnosed with a substance use disorder, as determined by meeting a one or higher level on the American Society of Addiction Medicine Criteria
  - ADL's
  - The client a homeless individual with a disability, determined by a coordinated entry assessment.
- Risk Factors
  - Chronic Homelessness
  - Frequent or lengthy institutional contacts
  - Frequent of lengthy stays in adult residential care
  - Frequent turnover of in-home caregivers
  - PRISM Risk score of 1.5 or above

Next Steps

- Authorization Form to FCS Coordinator for Review
- Submit to AmeriGroup
- Assign to a Case Manager (Pathways/FCS/Housing Program)

I wish I could be more helpful, but that would violate company policy.

Case Management Framework

- Pathways Assessment Tool
- Develop a Pathways Stability Plan
- Emphasis on Care Coordination
- Pathways are Prescriptive

20 Care Coordination Pathways

- Adult Education
- Employment
- Health Insurance
- Housing
- Medical Home
- Medical Referral
- Medication Assessment
- Medication Management
- Smoking Cessation
- Family Planning
- Social Service Referral
- Behavioral Referral
- Developmental Screening
- Developmental Referral
- Education
- Immunization Screening
- Immunization Referral
- Lead Screening
- Pregnancy
- Postpartum

Braiding Funding Sources

- Grant Housing Subsidies (HEN,CHG,TBRA,HUD)
- FCS for Pre-Post Housing Support Services (Fee for Service)
- Pathways (Performance Funding)

Access for All Clients Seeking Services

Comprehensive/Holistic Support Services

Adequate Resources

Quality Supportive Housing Services that Transform Lives

Budget – Time Allocation

- One Case Manager
- Caseload of 20
- 1-year of Service
- $120,000 in fee for service reimbursements

- 65 - 95 units per case manager = $6,825 to $9,975 per month
- Average caseload 16 to 20 “active” clients
- 70% of a full-time case manager’s time should be “billable”
- 160 hours in a month @ 70% is 112 hours

Our Challenges

- Timely Verification
- Too Many Denials
- New Client Issues
- More Interdependent on Community Partners
- Leads to Teams
- Expensive
- Accountability Tension
- Demand Exceeds Capacity
- Failing Forward is Taxing – Positive Restlessness

Questions

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